Senate Bill No. 1103

CHAPTER 228

An act to amend Section 17002 of the Corporations Code, to amend Section 6254 of the Government Code, to amend Sections 1341.4, 1575.5, 101315, 101319, 101750, 123707, 124977, 124980, 125000, 125001, and 127671 of, to add Sections 101320, 101750.5, and 120956 to, to add Chapter 5 (commencing with Section 123223) to Part 1 of Division 106 of, and to repeal Article 6 (commencing with Section 101315) of Chapter 3 of Part 3 of Division 101 of, the Health and Safety Code, to amend Section 12693.43 of, and to repeal Section 12699.10 of, the Insurance Code, and to amend Sections 4094.2, 4631.5, 4643, 4648.4, 4681.5, 4691.6, 4781.5, 5775, 14007.9, 14018.7, 14044, 14085.7, 14085.8, 14087.31, 14087.35, 14087.36, 14087.38, 14087.51, 14087.54, 14087.9605, 14094.3, 14105.19, 14105.336, 14105.337, 14132.100, 14574, 16809, 22003, and 22009 of, to amend and repeal Section 14464.5 of, to add Sections 4865.1, 14043.46, 14132.107, 14132.108, 14133.01, 14154.5, 14170.11, 14552.5, and 22005.2 to, to add and repeal Sections 4783 and 14132.105 of, to repeal Sections 14105.46 and 14110.65 of, and to repeal and add Section 14105.45 of, the Welfare and Institutions Code, and to repeal Section 80.5 of Chapter 230 of the Statutes of 2003, relating to health, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor August 16, 2004. Filed with Secretary of State August 16, 2004.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1103, Committee on Budget and Fiscal Review. Budget Act of 2004: health.

(1) Existing law provides that subject to any limitations contained in the articles of organization and to compliance with any other applicable laws, a limited liability company may engage in any lawful business activity, except the banking business, the business of issuing policies of insurance and assuming insurance risks, or the trust company business.

This bill would authorize, notwithstanding this provision, a limited liability company to operate as a health care service plan if the limited liability company is a subsidiary of a health care service plan and is established to serve an existing line of business of the parent health care service plan.

(2) The California Public Records Act provides that its provisions shall not be construed to require disclosure, during a prescribed time

period, of the records of specified Medi-Cal program contracts that reveal the special negotiator's deliberative processes, discussions, or communications. Existing law requires, however, the entire contract or amendment to be open to inspection by the Joint Legislative Audit Committee and requires the committee to maintain the confidentiality of the contracts.

This bill would require the entire contract or amendment to also be open to inspection by the Legislative Analyst's office and would require the office to maintain the confidentiality of the contracts and amendments.

(3) Existing law requires the Governor to convene the California Health Care Quality Improvement and Cost Containment Commission and prescribes the composition of the commission. Existing law requires the commission to examine and address 9 health care issues. Existing law requires the commission to issue a report to the Legislature and the Governor, on or before January 1, 2005, making recommendations for health care cost containment.

This bill would require the commission to issue its report, instead, on or before January 1, 2006.

(4) Existing law establishes the Managed Care Fund in the State Treasury in order to support the Department of Managed Care in the administration of laws related to the licensure and regulation of health care service plans. The fund consists of licensing and regulatory services fees charged to health care service plans and administrative penalties.

This bill would authorize the use of up to $364,000 from the Managed Care Fund for the 2004–05 and 2005–06 fiscal years to support staff and related functions associated with the California Health Care Quality Improvement and Cost Containment Commission.

(5) Existing law requires the Director of Health Services, to the extent that state and federal funds are appropriated in the Budget Act for this purpose, to establish a program, known as the AIDS Drug Assistance Program (ADAP), to provide drug treatments to persons infected with human immunodeficiency virus (HIV).

This bill would create the AIDS Drug Assistance Program (ADAP) Rebate Fund as a special fund in the State Treasury, into which would be deposited all rebates collected from drug manufacturers on drugs purchased through ADAP, and interest earned on these moneys, and which would be continuously appropriated to the department to cover costs related to ADAP.

(6) Under existing law, the Director of Health Services administers the Genetically Handicapped Person's Program for the medical care of persons with genetically handicapping conditions.

Existing law also requires the State Department of Health Services to administer the California Children's Services Program, to provide services to physically handicapped children under 21 years of age.

This bill would create the continuously appropriated Children's Medical Services Rebate Fund as a special fund in the State Treasury into which would be deposited all rebates for the delivery of health related services and products for clients enrolled in the Genetically Handicapped Person's Program and the California Children's Services Program to cover costs related to those programs.

(7) Existing law states that in early 1992, the State Department of Health Services began a 4-year clinical trial of a potential new medicine, human Botulism Immune Globulin (BIG), specifically designed for the treatment of infant botulism and states that the funding for this clinical trial is being provided by the United States Food and Drug Administration (FDA). If the results of the clinical trial do not qualify BIG for product licensure by the FDA, existing law requires the Infant Botulism Treatment and Prevention Program to become inoperative on the date that the Commissioner of the FDA or his or her delegate so notifies the State Department of Health Services, and requires it to be repealed on January 1 following the receipt of the notice, unless a later enacted statute operative on or before that date deletes or extends that date. Existing law requires the director to transmit a written notice to the Secretary of the Senate and the Chief Clerk of the Assembly commemorating receipt of the notice from the commissioner.

This bill would repeal the above requirements. The bill would authorize the State Department of Health Services to manufacture, test, distribute, and maintain licensure of the product BIG if all necessary federal licenses are obtained. The bill would require contracts and commodity purchases for any manufacture, testing, distribution, packaging, development, and licensure of BIG by the department to be exempt from competitive bidding and from provisions relating to contracting by state agencies.

(7.1) Existing law establishes procedures and requirements to govern the allocation to, and expenditure by, local health jurisdictions, designated pursuant to a federally approved plan, of federal funding received for the prevention of, and response to, bioterrorist attacks and other public health emergencies. Existing law requires a local health jurisdiction receiving funds under these provisions to deposit the money in a special Local Public Health Preparedness Trust Fund. These provisions provide that federal funding received by the State Department of Health Services for bioterrorism preparedness and emergency response is subject to appropriation in the annual Budget Act commencing with the 2003–04 fiscal year.

This bill would extend these provisions to apply to public health preparedness and response by hospitals, clinics, emergency medical systems, and poison control centers. This bill would make these provisions inoperative on September 1, 2007, and would repeal them as of January 1, 2008.

(7.2) The Hereditary Disorders Act, among other provisions, declares the intent of the Legislature that the state's hereditary disorders program activities are to be fully supported by fees collected for services provided by the program, unless otherwise provided. Existing law requires the department to charge a fee to all payers for any tests or activities performed pursuant to provisions relating to genetic disorder prevention services, including the Hereditary Disorders Act. Existing law requires that any fee charged for screening and followup services provided to Medi-Cal eligible persons, health care service plan enrollees, or persons covered by disability insurance policies are to be paid directly to the Genetic Disease Testing Fund, a continuously appropriated fund, to be used for purposes of the Hereditary Disorders Act, subject to the terms and conditions of the applicable health care service plan or insurance coverage. Under existing law, all moneys collected by the department pursuant to the act must be deposited into the fund.

This bill instead would require that any fee charged for prenatal screening and followup services under these provisions be paid directly to the fund.

Existing law requires the State Department of Health Services to charge a fee for newborn screening and followup services, and requires the amount of the fee to be established pursuant to regulation and periodically adjusted by the director.

This bill would delete the requirement that the director establish and adjust the newborn screening fee.

This bill would require the department to convene a working group to evaluate newborn and prenatal screening billing procedures and to report its recommendations to the department by March 1, 2005. The bill would make legislative findings and declarations with respect to the need for expanded genetic testing of newborns in California.

(7.3) Existing law requires the Director of Health Services to establish necessary regulations and standards for hereditary disorders programs, in order to promote and protect the public health and safety. Existing law requires these standards to implement designated principles, including provisions for compensatory and civil damages for an individual whose confidentiality has been breached as a result of a violation of the Hereditary Disorders Act, as well as an award of attorney's fees and litigation costs.

This bill would revise the above provisions and would additionally provide for imprisonment, fines as prescribed, or both, for the knowing breach of confidentiality, including if the breach was made under false pretenses or committed with the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, of an individual tested under the act. By creating a new crime, the bill would impose a state-mandated local program.

(7.4) Existing law requires the State Department of Health Services to establish a genetic disease unit to coordinate all departmental programs in the area of genetic disease. Existing law requires the genetic disease unit to evaluate and prepare recommendations on the implementation of tests for the detection of certain hereditary and congenital diseases.

This bill would add biotinidase deficiency to the diseases for which the genetic disease unit is required to evaluate and prepare recommendations.

This bill would require the department to expand statewide screening of newborns to include tandem mass spectrometry screening for fatty acid oxidation, amino acid, and organic acid disorders and congenital adrenal hyperplasia, and to provide information with respect to these disorders and testing resources to all women receiving prenatal care and admitted to a hospital for delivery. If the department is unable to provide statewide screening for these disorders by July 1, 2005, the bill would require the department to temporarily obtain statewide screening for these disorders from one or more laboratories, through a competitive bid process. The bill would also enact related reporting requirements.

(7.5) Existing law establishes the Healthy Families Program, administered by the Managed Risk Medical Insurance Board, to arrange for the provision of health, dental, and vision services to eligible children pursuant to a federal program, entitled the State Children's Health Insurance Program. Eligibility requirements include being a child in a family with a household income equal to or less than 200% of the federal poverty level. Existing law requires applicants applying to the purchasing pool to agree to pay family contributions, unless the applicant has a family contribution sponsor.

This bill, commencing July 1, 2005, would revise the contribution amounts required to be paid under the program. To the extent this bill would increase amounts deposited in a continuously appropriated fund it would make an appropriation.

(7.6) Existing law establishes the Access for Infants and Mothers Program (AIM), which is administered by the Managed Risk Medical Insurance Board and under which the board contracts with a variety of

health plans and types of health care service delivery systems in order to offer subscribers a choice of plans, providers, and types of service delivery and to negotiate or arrange for stop-loss insurance coverage. Existing law establishes in the State Treasury the Perinatal Insurance Fund, which is administered by the board. The board is required to establish a reserve sufficient to prudently operate AIM.

This bill would delete the requirement that the board establish a reserve for the operation of the program.

(8) Existing law contains provisions relating to the setting of reimbursement rates for community treatment facilities, as defined. Existing law authorizes up to 400 community treatment facility beds statewide pursuant to these provisions, and anticipates a phased-in implementation of community treatment facilities, with the average monthly community treatment facility caseload increasing by 175 beds by the 2003–04 fiscal year.

This bill would eliminate this schedule for the increase in community treatment facility beds statewide.

(9) Existing law requires, for the 2003–04 fiscal year, that community treatment facility programs be paid a supplemental rate of up to $2,500 per child per month on behalf of children eligible for foster care and seriously emotionally disturbed children placed out of home pursuant to an individualized education program. Existing law requires, subject to the availability of funds, that this supplemental rate be shared by the state and the counties, as prescribed.

This bill would extend the requirement to pay the supplemental rate to the 2004–05 fiscal year.

(10) Under existing law, the State Department of Developmental Services allocates funds to private nonprofit entities known as regional centers for the provision of community services and support for persons with developmental disabilities and their families. Existing law requires the department, after consultation with stakeholder groups, to develop a system of enrollment fees, copayments, or both to be assessed against the parents of certain children receiving services through a regional center.

This bill would create the Family Cost Participation Program in the department to assess a cost participation to the parents of certain children receiving respite, day care, and camping services through a regional center. The bill would require the department to develop a schedule to be used by regional centers to assess a parents' cost participation and would specify requirements for assessments under the schedule. The bill would provide that, commencing January 1, 2005, each regional center is responsible for administering the program and would specify various requirements for regional centers. The bill would require that the

department, among other things, report to the Legislature on the status of the program, commencing April 1, 2005, and annually thereafter. The bill would make these provisions inoperative on July 1, 2009, and would repeal these provisions as of January 1, 2010.

(10.2) Existing law requires the State Department of Developmental Services to determine, within 30 days of the enactment of the annual Budget Act, the amount of unallocated reduction that each regional center shall make in its purchase-of-service budget, and provide to each regional center guidelines, technical assistance, and options for reducing costs. Existing law requires each regional center to develop, and submit, a plan to the department describing in detail how it intends to absorb the unallocated reduction and achieve necessary savings. Existing law requires the regional center to hold a public hearing prior to adopting the plan and to include in the plan a summary of a response to public testimony. Existing law requires the regional center to implement components of the plan upon a review and approval of the plan by the department. These provisions become inoperative July 1, 2005, and are repealed on January 1, 2006.

This bill would extend the inoperative and repeal dates of these provisions to July 1, 2006, and January 1, 2007, respectively.

This bill would require the department to develop a methodology for apportioning the 2004–05 unallocated reduction from the General Fund of $7,000,000 to the regional center purchase-of-service budget and to provide this information to the fiscal and applicable policy committees of both houses of the Legislature on or before December 1, 2004. The bill would also require the department to provide a summary of the approved components of the regional center plans to meet the unallocated amount.

(10.3) Existing law provides that any person believed to have a developmental disability, and any person believed to have a high risk of parenting a developmentally disabled infant shall be eligible for initial intake and assessment services in the regional centers. Existing law requires that if assessment is needed, prior to July 1, 2004, the assessment shall be performed within 120 days following initial intake, and on and after July 1, 2004, the assessment shall be performed within 60 days following intake.

This bill would permit initial intake to be performed within 120 days following intake prior to July 1, 2005, and would require initial intake to be performed within 60 days following intake on and after July 1, 2005.

(10.4) Existing law prohibits, during the 2003–04 fiscal year, a regional center from paying any provider of 11 services and supports a rate, or approving any service level for a residential service provider that

would result in an increase in the rate to be paid, that is greater than the rate that is in effect on or after June 30, 2003, with exceptions.

This bill, instead, would prohibit, during the 2004–05 fiscal year, a regional center from paying any provider of these services a rate, or approving any service level for a residential service provider that would result in an increase in the rate to be paid, that is greater than the rate that is in effect on or after June 30, 2004, with exceptions.

(10.5) Existing law prohibits, during the 2003–04 fiscal year, the department from establishing any permanent payment rate for a community-based day program or in-home respite service agency provider that has a temporary payment rate in effect on June 30, 2003, if that permanent payment rate would be greater than the rate in effect on or after June 30, 2003, except as prescribed. Existing law also prohibits, during the 2003–04 fiscal year, the department from approving an anticipated rate adjusted for a community-based program or in-home respite service agency provider that would result in a similar increase, except as prescribed. Existing law prohibits, during the 2003–04 fiscal year, the department and a regional center from approving any program design modification or revendorization for a community-based day program or in-home respite service agency provider that would result in a similar increase, except as prescribed.

This bill, instead, would apply these prohibitions and exceptions to the 2004–05 fiscal year and to rates in effect on June 30, 2004, if the rates would be greater than the rate in effect on or after June 30, 2004.

(10.6) Under existing law, among those services for which regional centers contract are habilitation services.

This bill would prohibit any rate adjustment for a habilitation services program that would result in an increase in the rate to be paid to the vendor from that rate that is in effect on or after June 30, 2004, for the 2004–05 fiscal year, unless the regional center demonstrates that the rate adjustment is necessary to protect the consumer's health and safety and the department has granted prior written authorization.

(10.7) Existing law establishes the Habilitation Services Program under the administration of the Department of Rehabilitation, and on July 1, 2004, transfers the administration of this program to the State Department of Developmental Services. Existing law establishes the hourly rate for supported employment services provided to clients receiving individualized services and group services under the program. Existing law defines ''group services'' as job coach-supported employment services in a group supported employment placement at a job coach-to-client ratio of not less than 1:4 nor more than 1:8 where a minimum of 4 clients are department funded. However, existing law authorizes group services on or after July 1, 2002, and not to be funded

beyond June 30, 2004, in a group at a job coach-to-client ratio of 1:3 if certain conditions are met.

This bill would require a regional center to pay the rate in effect on June 30, 2004, for a supported employment placement group composed of a coach-to-client ratio of 1:3 when the provider submits, by June 30, 2004, documentation to the department and the regional center that 3 conditions exist.

(10.8) Existing law prohibits, during the 2002–03 and 2003–04 fiscal years only, a regional center from expending any purchase of service funds for the startup of any new program, with exceptions.

This bill would apply this prohibition, instead, to the 2004–05 and 2005–06 fiscal years.

(10.9) Existing law requires the State Department of Mental Health to implement managed mental health care Medi-Cal benefits through fee-for-service or capitated rate contracts with mental health plans. Existing law provides that emergency regulations adopted by the department to implement the 2nd phase of mental health managed care shall remain in effect until July 1, 2004, or until the regulations are made permanent, whichever occurs first.

This bill would provide, instead, that the emergency regulations shall remain in effect until January 1, 2006. The bill would also require the department to convene at least 2 public hearings to clarify new federal regulations that affect the state's 2nd phase of mental health managed care and to report to the Legislature on the results of the hearings through the 2005–06 budget deliberations.

(10.10) The California Adult Day Health Care Act provides for the licensure and regulation of adult day health centers, with administrative responsibility for this program shared between the State Department of Health Services and the California Department of Aging. The Adult Day Health Medi-Cal Law establishes adult day health care services as a Medi-Cal benefit for Medi-Cal beneficiaries who meet certain criteria.

This bill would authorize the department to implement a one-year moratorium on the certification and enrollment into the Medi-Cal program of adult day health care centers on a statewide basis or within a geographic area. The bill would exempt, or in some cases authorize the department to except from the moratorium applicants that meet certain conditions. The bill would provide that the department is not prohibited from approving a change of ownership, relocation, or increase in capacity of an adult day health care center if the center meets certain conditions.

(10.11) Existing law requires that concurrently with the submission of an application for initial licensure as an adult day health center, the applicant also apply to the department for eligibility certification as a

provider of adult day health care services reimbursable under the Medi-Cal program.

This bill would provide that this provision shall not apply to new centers licensed during a moratorium imposed in accordance with (10.10) above, nor upon the implementation of an adult day health care waiver under the Welfare and Institutions Code.

(10.12) Existing law requires the department to terminate Medi-Cal certification of an adult day health care provider who is not in compliance with the Medi-Cal program. Existing law provides that proceedings to deny an application for certification or licensure, terminate or suspend certification, or revoke or suspend licensure shall be consolidated whenever possible, and requires the California Department of Aging and the State Department of Health Services to coordinate an action or actions under these provisions to the extent appropriate to ensure consistency and uniformity.

This bill would provide that these provisions would not apply to denials of initial Medi-Cal certification made pursuant to the one-year adult day health care center medi-cal moratorium permitted by the bill. This bill would delete the requirement that the 2 departments coordinate proceedings to deny an application for licensure.

(11) Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Services and pursuant to which health care services are provided to qualified low-income persons.

Existing law, until April 1, 2005, and subject to the receipt of federal financial participation, requires the department to adopt a federal option under which any employed individual whose countable income, determined by criteria specified in the bill, does not exceed 250% of the federal poverty level and who is disabled under certain federal laws, shall be eligible for benefits under the Medi-Cal program, subject to the payment of premiums. These provisions are repealed on January 1, 2006.

This bill would extend the operation of these provisions to September 1, 2008, and their repeal date to January 1, 2009.

Because counties are required to make Medi-Cal eligibility determinations and this bill would extend the expansion of Medi-Cal eligibility, the bill would impose a state-mandated local program.

(11.5) Existing law authorizes the department to limit, for 18 months or less, certain codes for which any provider may bill, or for which reimbursement to any person or entity may be made by, the Medi-Cal program or other health care programs administered by the department if the department determines that excessive services or billings, or abuse, has occurred.

This bill would provide that this circumstance may include the department's discovery or determination that a claim was submitted for reimbursement under the Medi-Cal program for a nerve conduction test, electromyography, or procedures, tests, examinations, or other medical services that the department has specified requires a certain residency or board certification, but the records did not contain, or the person or entity submitting the claim for reimbursement did not have, the certificate or diploma required by law.

(12) Existing law creates the Medi-Cal Medical Education Supplemental Payment Fund in the State Treasury as a continuously appropriated fund, which consists of various moneys for use by public agencies for health care programs or purposes. Under existing law, these provisions become inoperative on July 1, 2004, and as of January 1, 2005, are repealed.

Existing law creates the Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund in the State Treasury and provides that the fund is continuously appropriated to, and under the administrative control of, the department for specified purposes. Existing law makes these provisions inoperative on July 1, 2004, and provides for the repeal on January 1, 2005.

This bill would eliminate the inoperative and repeal dates, thereby extending the operation of these provisions indefinitely. By extending indefinitely the operation of a continuously appropriated fund, this bill would result in an appropriation.

(13) Existing law provides that in counties selected by the Director of Health Services with the concurrence of the county, a special county health authority may be established, and in any county, by ordinance, a special commission may be established, in order to meet the problems of delivery of publicly assisted medical care in each county, and to demonstrate ways of promoting quality care and cost efficiency. Existing law also specifically authorizes the County of Alameda and the City and County of San Francisco to establish, by ordinance, a health authority and Kern County, Tulare County, San Joaquin County, San Mateo County, and Los Angeles County to establish, by ordinance, a special county health commission. Existing law establishes the Santa Barbara Regional Health Authority.

Existing law sets forth procedures governing claims and actions against public entities and public employees. Commissions or health authorities, in some cases, are considered a public entity for purposes of, or, with exceptions, are protected by the immunities applicable to public entities and public employees governed by, these provisions relating to claims and actions against public entities and public employees.

Existing law, the Joint Exercise of Powers Act, sets forth procedures under which public agencies or entities may enter into joint powers agreements.

This bill would provide that these health authorities or commissions shall be considered a public entity for purposes of those provisions governing claims and actions against public entities and public employees. The bill would specify persons for which health care services may be provided by certain of these entities, and would authorize these entities to enter into joint powers agreements under the Joint Exercise of Powers Act.

(14) Existing law prohibits California Children's Services (CCS) covered services from being incorporated into certain Medi-Cal managed care contracts entered into after August 1, 1994, until August 1, 2005, except for contracts entered into for county organized health systems in the Counties of San Mateo, Santa Barbara, Solano, Yolo, Marin, and Napa.

This bill would instead prohibit CCS covered services from being incorporated into certain Medi-Cal managed care contracts entered into after August 1, 1994, until September 1, 2008, except for contracts entered into for county organized health systems or Regional Health Authority in the above counties.

(14.5) Existing law requires the Director of Health Services to reduce Medi-Cal provider payments by 5%. Existing law provides for 9 exemptions from this payment reduction.

Existing law establishes the Child Health and Disability Prevention Program, administered by the State Department of Health Services, to provide early and periodic assessments of the health status of children, including health screening and referral services.

Existing law establishes the Multipurpose Senior Services Program to serve frail elderly individuals 65 years of age and older who are certifiable for placement in a nursing facility. The program is administered by the California Department of Aging under the authority of an approved interagency agreement with the State Department of Health Services.

This bill would exempt services provided on or after July 1, 2004, through the California Children's Services Program, the Genetically Handicapped Persons Program, the Child Health and Disability Prevention Program, the Multipurpose Senior Services Program, and the Breast and Cervical Cancer Early Detection Program from the Medi-Cal payment reduction. The bill would also exempt, effective September 1, 2004, legend and nonlegend drugs dispensed by pharmacy providers reimbursed under the Medi-Cal program.

(15) Existing law requires the State Department of Health Services to reduce reimbursements to pharmacists by $0.50 per prescription, effective January 1, 1995, for all drug prescription claims reimbursed through the Medi-Cal program.

Existing law, until July 1, 2004, requires the department to increase reimbursement to pharmacists per prescription for all drug prescription claims reimbursed through the Medi-Cal program on January 1, 2000, and on July 1, 2002. Existing law requires the department to reduce reimbursement by those amounts to pharmacists on a specified date, with the exception of claims submitted by pharmacists for beneficiaries residing in a nursing facility.

This bill would make those provisions inoperative on September 1, 2004.

(16) Existing law requires the department to establish a list of maximum allowable ingredient costs (MAIC) for drugs.

This bill would revise the method of determining the maximum allowable ingredient costs.

(16.5) Existing law requires the State Department of Health Services, upon federal approval of a Medicaid state plan amendment, to provide a supplemental rate adjustment to the Medi-Cal reimbursement rate for specific nursing facilities, intermediate care facilities/developmentally disabled, intermediate care facilities/developmentally disabled-habilitative, intermediate care facilities/developmentally disabled-nursing, and pediatric subacute units that have a collectively bargained contract or a comparable legally binding, written commitment to increase salaries, wages, or benefits for nonmanagerial, nonadministrative, and noncontract staff. Existing law requires, solely for the period commencing February 1, 2002, to July 31, 2004, inclusive, the department to pay this rate adjustment to the extent that a facility submits a rate adjustment request to the department within a specified period of time, and the department approves the supplemental rate adjustment for the particular facility.

This bill would repeal these provisions.

(17) Existing law establishes requirements as a condition of obtaining a contract with the department to provide Medi-Cal services, and provides that a federally qualified health center or rural health clinic may voluntarily agree to enter into a capitated or other at-risk contract with a managed care program health plan if the clinic agrees to specified conditions. Existing law provides that federally qualified health center services and rural health clinic services, as defined, are covered benefits under the Medi-Cal program, to be reimbursed to providers on a per-visit basis, pursuant to various requirements.

This bill would authorize the department to adopt emergency regulations to implement these reimbursement provisions. The bill also would authorize, notwithstanding this provision, the director to issue instructions and forms to implement certain of these provisions. This bill would repeal this provision as of July 1, 2006.

(18) Existing law authorizes an FQHC or RHC to apply for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC.

This bill would revise the circumstances under which a change in costs, in and of itself, is considered a scope-of-service change. This bill also would establish timeframes for the processing and payment of claims for reimbursement under these provisions by the department and would specify circumstances under which a request for rate adjustment for scope-of-service rate changes may be deemed filed in a timely manner.

This bill would also state the intent of the Legislature that retroactive payments owed to FQHCs and RHCs for the period that began January 1, 2001, and proceeds through June 30, 2004, be made in the 2004–05 fiscal year.

(19) Under existing law, one of the utilization controls to which services are subject under the Medi-Cal program is the treatment authorization request process, which is approval by a department consultant of a specified service in advance of the rendering of that service based upon a determination of medical necessity.

This bill would authorize the director or his or designee to apply prior authorization by designing a sampling methodology, as prescribed, that will result in a generally acceptable audit standard for approval of a treatment authorization request (TAR) or a class of TARs. The bill would require the department to pursue additional means to improve and streamline the TAR process.

(20) Existing law establishes the Medi-Cal Eligibility Data System (MEDS) regarding the status of applications for Medi-Cal coverage.

This bill would require counties to work MEDS error alerts as prescribed, to submit quarterly reconciliation files to the department, and, in some cases, to submit corrective action plans. The bill would authorize the department to impose a 2% reduction in the allocation of funds to a county that fails to meet interim benchmarks for improvement standards required to be in a corrective action plan.

(21) Existing law requires, with certain exceptions, the records of a Medi-Cal provider submitting a claim for the dispensing or furnishing of a controlled drug, dangerous drug, or a dangerous device requiring a prescription for coverage under the Medi-Cal program to contain an order or prescription authorized under the Pharmacy Law.

This bill would prohibit a person or entity from submitting a claim under the Medi-Cal program for a nerve conduction test or for electromyography unless the records of the person or entity contain a copy, for each person performing each test or electromyography, of a certificate or diploma of satisfactory completion of a specific accreditation program.

(22) Existing law authorizes the Director of Health Services to enter into contracts with managed care plans to provide services under the Medi-Cal program. Existing law authorizes the department, if approval for federal financial participation is obtained, to impose, annually, a quality improvement fee on the capitation payments paid to a Medi-Cal managed care plan, as defined, with the fees to be used to provide capitation rate increases for Medi-Cal managed care plan's quality improvement. Existing law requires the department to determine the percentage of each plans capitation payments to be paid monthly, not to exceed 6% and excludes from these provisions certain state supported services contracts and payments derived from intergovernmental transfers and associated federal financial participation. Existing law prohibits the department from assessing or collecting the fees if conditions related to compliance with federal requirements are not met. Existing law also prohibits the department from collecting fees under these provisions before January 1, 2004.

This bill would revise these provisions to instead require the department to impose, annually, a quality improvement fee no earlier than January 1, 2005, to be paid monthly at 6% of the total operating revenue of each Medi-Cal managed care plan, as redefined by the bill. The bill would authorize the department to alter the methodology for calculating and imposing the fee to the extent necessary to meet federal requirements. The bill would require that the capitation rates that a managed care plan would otherwise receive for providing services to Medi-Cal beneficiaries be increased, as determined by the department subject to 3 requirements. This bill would delete the exclusions from these fee provisions and the prohibition against the department collecting fees before January 1, 2004. This bill would make this provision inoperative January 1, 2009, and would repeal this provision July 1, 2009.

(23) Existing law provides that the board of supervisors of a county that contracted with the State Department of Health Services pursuant to a specified provision of law during the 1990–91 fiscal year and any county with a population under 300,000, as determined in accordance with the 1990 decennial census, by adopting a resolution to that effect, may elect to participate in the County Medical Services Program for

state administration of health care services to eligible persons in the county.

This bill would revise, for the 2004–05 fiscal year, state and counties financial responsibilities for certain increases in costs in the County Medical Services Program.

(24) Existing law establishes the California Partnership for Long-Term Care Program. The purpose of the program is to link private long-term care insurance and health care service plan contracts that cover long-term care with the In-Home Supportive Services program and Medi-Cal and to provide Medi-Cal benefits to certain individuals who have income and resources above the eligibility levels for receipt of medical assistance, but who have purchased certified private long-term care insurance policies and subsequently exhausted the benefits of these private policies. Existing law requires that the resource protection provided by the program be effective only for long-term care policies and health care service plans delivered, issued for delivery, or renewed during an enrollment period of July 1, 1993, to January 1, 2005, inclusive.

This bill would extend the program to long-term care policies and health care service plans delivered, issued for delivery, or renewed on July 1, 1993, and thereafter.

This bill would require each organization issuing policies certified by the State Department of Health Services under the program to annually contribute not less than $20,000 to a fund to be used for common educational and marketing expenses for reaching the target population.

(25) Under the California Partnership for Long-Term Care Program, individuals who participate in the program remain eligible for those in-home supportive services benefits and those Medi-Cal benefits for which they are eligible under the program for the life of the purchaser of the policy or contract, as long as the purchaser maintains his or her insurance policy or health care service plan contract in force, or otherwise qualifies for continued benefits in accordance with regulations promulgated by the departments. Existing law requires the State Department of Health Services and the State Department of Social Services to jointly adopt regulations that provide for the continuation of benefits beyond the termination of the program.

This bill, instead, would require that the jointly adopted regulations provide for continuation of benefits pursuant to the program.

(25.5) Existing law requires that the Medi-Cal reimbursement rate in effect for the 2003–04 fiscal year for hospitals, not under contract with the California Medical Assistance Commission, providing inpatient services to Medi-Cal recipients to remain the same for the entire 2004–05 fiscal year.

This bill would repeal this provision.

(26) Existing law provides that, notwithstanding any other provision of law or regulation, the Medi-Cal reimbursement rates in effect for the 2003–04 fiscal year for hospitals, not under contract with the California Medical Assistance Commission, providing inpatient services to Medi-Cal recipients shall remain the same for the entire 2004–05 fiscal year, and states the intent of the Legislature that the California Medical Assistance Commission freeze all Medi-Cal reimbursement rates paid to hospitals for inpatient services at their 2003–04 contract rate, or at a lower level, whichever is applicable based on contract negotiations.

The bill would establish maximum limits for the amounts paid to acute care hospitals not under contract with the State Department of Health Services for inpatient services provided to Medi-Cal recipients during the 2004–05 fiscal year.

(27) Under existing law, the State Department of Mental Health has jurisdiction over 5 state hospitals, including the Metropolitan State Hospital, and each hospital is governed by uniform rules and regulations of the department and state law governing the administration of state institutions for the mentally disordered.

This bill would require that, in response to a report of the United States Department of Justice, Civil Rights Division, regarding the operation of the Metropolitan State Hospital, the State Department of Mental Health submit quarterly reports to the Legislature regarding, at least, 6 key measures that pertain to the operation of the Metropolitan State Hospital, provide to the Legislature all future correspondence between the United States Department of Justice and the State Department of Mental Health regarding Metropolitan State Hospital, provide to the Legislature quarterly updates of the Metropolitan State Hospital ''Summary Grid'' for compliance, and convene at least 2 community forums within the 2004–05 fiscal year at the Metropolitan State Hospital.

(28) The bill would require the State Department of Mental Health, in collaboration with the Department of Managed Health Care, the Department of Insurance, and applicable representatives from the California public and private mental health systems, to identify the core reasons that mental health parity in California is not being achieved, the barriers to achieving that parity, and what approaches over the short term and long term can be done to effectuate a more comprehensive mental health system in California, both public and private. The bill would require the State Department of Mental Health to submit a report of this information to the Legislature on or before March 1, 2005.

(29) The bill would require the State Department of Health Services, in collaboration with the County Welfare Directors Association, to develop options and recommendations for modifying the budgeting and

allocation methodologies for county Medi-Cal administration. The bill would require the department to report the options and recommendations developed pursuant to this provision to all fiscal committees of both houses of the Legislature on or before January 10, 2005.

(30) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed $1,000,000 statewide and other procedures for claims whose statewide costs exceed $1,000,000.

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

(31) The bill would declare that it is to take effect immediately as an urgency statute.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 17002 of the Corporations Code is amended to read:

17002. (a) Subject to any limitations contained in the articles of organization and to compliance with any other applicable laws, a limited liability company may engage in any lawful business activity, except the banking business, the business of issuing policies of insurance and assuming insurance risks, or the trust company business.

(b) Notwithstanding subdivision (a), a limited liability company may operate as a health care service plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code if the limited liability company is a subsidiary of a health care service plan licensed pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code and is established to serve an existing line of business of the parent health care service plan.

SEC. 2. Section 6254 of the Government Code is amended to read:

6254. Except as provided in Sections 6254.7 and 6254.13, nothing in this chapter shall be construed to require disclosure of records that are any of the following:

(a) Preliminary drafts, notes, or interagency or intra-agency memoranda that are not retained by the public agency in the ordinary

course of business, provided that the public interest in withholding those records clearly outweighs the public interest in disclosure.

(b) Records pertaining to pending litigation to which the public agency is a party, or to claims made pursuant to Division 3.6 (commencing with Section 810), until the pending litigation or claim has been finally adjudicated or otherwise settled.

(c) Personnel, medical, or similar files, the disclosure of which would constitute an unwarranted invasion of personal privacy.

(d) Contained in or related to any of the following:

(1) Applications filed with any state agency responsible for the regulation or supervision of the issuance of securities or of financial institutions, including, but not limited to, banks, savings and loan associations, industrial loan companies, credit unions, and insurance companies.

(2) Examination, operating, or condition reports prepared by, on behalf of, or for the use of, any state agency referred to in paragraph (1).

(3) Preliminary drafts, notes, or interagency or intra-agency communications prepared by, on behalf of, or for the use of, any state agency referred to in paragraph (1).

(4) Information received in confidence by any state agency referred to in paragraph (1).

(e) Geological and geophysical data, plant production data, and similar information relating to utility systems development, or market or crop reports, that are obtained in confidence from any person.

(f) Records of complaints to, or investigations conducted by, or records of intelligence information or security procedures of, the office of the Attorney General and the Department of Justice, and any state or local police agency, or any investigatory or security files compiled by any other state or local police agency, or any investigatory or security files compiled by any other state or local agency for correctional, law enforcement, or licensing purposes, except that state and local law enforcement agencies shall disclose the names and addresses of persons involved in, or witnesses other than confidential informants to, the incident, the description of any property involved, the date, time, and location of the incident, all diagrams, statements of the parties involved in the incident, the statements of all witnesses, other than confidential informants, to the victims of an incident, or an authorized representative thereof, an insurance carrier against which a claim has been or might be made, and any person suffering bodily injury or property damage or loss, as the result of the incident caused by arson, burglary, fire, explosion, larceny, robbery, carjacking, vandalism, vehicle theft, or a crime as defined by subdivision (b) of Section 13951, unless the disclosure would endanger the safety of a witness or other person involved in the

investigation, or unless disclosure would endanger the successful completion of the investigation or a related investigation. However, nothing in this division shall require the disclosure of that portion of those investigative files that reflect the analysis or conclusions of the investigating officer.

Customer lists provided to a state or local police agency by an alarm or security company at the request of the agency shall be construed to be records subject to this subdivision.

Notwithstanding any other provision of this subdivision, state and local law enforcement agencies shall make public the following information, except to the extent that disclosure of a particular item of information would endanger the safety of a person involved in an investigation or would endanger the successful completion of the investigation or a related investigation:

(1) The full name and occupation of every individual arrested by the agency, the individual's physical description including date of birth, color of eyes and hair, sex, height and weight, the time and date of arrest, the time and date of booking, the location of the arrest, the factual circumstances surrounding the arrest, the amount of bail set, the time and manner of release or the location where the individual is currently being held, and all charges the individual is being held upon, including any outstanding warrants from other jurisdictions and parole or probation holds.

(2) Subject to the restrictions imposed by Section 841.5 of the Penal Code, the time, substance, and location of all complaints or requests for assistance received by the agency and the time and nature of the response thereto, including, to the extent the information regarding crimes alleged or committed or any other incident investigated is recorded, the time, date, and location of occurrence, the time and date of the report, the name and age of the victim, the factual circumstances surrounding the crime or incident, and a general description of any injuries, property, or weapons involved. The name of a victim of any crime defined by Section 220, 261, 261.5, 262, 264, 264.1, 273a, 273d, 273.5, 286, 288, 288a, 289, 422.6, 422.7, 422.75, or 646.9 of the Penal Code may be withheld at the victim's request, or at the request of the victim's parent or guardian if the victim is a minor. When a person is the victim of more than one crime, information disclosing that the person is a victim of a crime defined by Section 220, 261, 261.5, 262, 264, 264.1, 273a, 273d, 286, 288, 288a, 289, 422.6, 422.7, 422.75, or 646.9 of the Penal Code may be deleted at the request of the victim, or the victim's parent or guardian if the victim is a minor, in making the report of the crime, or of any crime or incident accompanying the crime, available to the public in compliance with the requirements of this paragraph.

(3) Subject to the restrictions of Section 841.5 of the Penal Code and this subdivision, the current address of every individual arrested by the agency and the current address of the victim of a crime, where the requester declares under penalty of perjury that the request is made for a scholarly, journalistic, political, or governmental purpose, or that the request is made for investigation purposes by a licensed private investigator as described in Chapter 11.3 (commencing with Section 7512) of Division 3 of the Business and Professions Code, except that the address of the victim of any crime defined by Section 220, 261, 261.5, 262, 264, 264.1, 273a, 273d, 273.5, 286, 288, 288a, 289, 422.6, 422.7, 422.75, or 646.9 of the Penal Code shall remain confidential. Address information obtained pursuant to this paragraph shall not be used directly or indirectly to sell a product or service to any individual or group of individuals, and the requester shall execute a declaration to that effect under penalty of perjury.

(g) Test questions, scoring keys, and other examination data used to administer a licensing examination, examination for employment, or academic examination, except as provided for in Chapter 3 (commencing with Section 99150) of Part 65 of the Education Code.

(h) The contents of real estate appraisals or engineering or feasibility estimates and evaluations made for or by the state or local agency relative to the acquisition of property, or to prospective public supply and construction contracts, until all of the property has been acquired or all of the contract agreement obtained. However, the law of eminent domain shall not be affected by this provision.

(i) Information required from any taxpayer in connection with the collection of local taxes that is received in confidence and the disclosure of the information to other persons would result in unfair competitive disadvantage to the person supplying the information.

(j) Library circulation records kept for the purpose of identifying the borrower of items available in libraries, and library and museum materials made or acquired and presented solely for reference or exhibition purposes. The exemption in this subdivision shall not apply to records of fines imposed on the borrowers.

(k) Records, the disclosure of which is exempted or prohibited pursuant to federal or state law, including, but not limited to, provisions of the Evidence Code relating to privilege.

(*l*) Correspondence of and to the Governor or employees of the Governor's office or in the custody of or maintained by the Governor's Legal Affairs Secretary, provided that public records shall not be transferred to the custody of the Governor's Legal Affairs Secretary to evade the disclosure provisions of this chapter.

(m) In the custody of or maintained by the Legislative Counsel, except those records in the public database maintained by the Legislative Counsel that are described in Section 10248.

(n) Statements of personal worth or personal financial data required by a licensing agency and filed by an applicant with the licensing agency to establish his or her personal qualification for the license, certificate, or permit applied for.

(o) Financial data contained in applications for financing under Division 27 (commencing with Section 44500) of the Health and Safety Code, where an authorized officer of the California Pollution Control Financing Authority determines that disclosure of the financial data would be competitively injurious to the applicant and the data is required in order to obtain guarantees from the United States Small Business Administration. The California Pollution Control Financing Authority shall adopt rules for review of individual requests for confidentiality under this section and for making available to the public those portions of an application that are subject to disclosure under this chapter.

(p) Records of state agencies related to activities governed by Chapter 10.3 (commencing with Section 3512), Chapter 10.5 (commencing with Section 3525), and Chapter 12 (commencing with Section 3560) of Division 4 of Title 1, that reveal a state agency's deliberative processes, impressions, evaluations, opinions, recommendations, meeting minutes, research, work products, theories, or strategy, or that provide instruction, advice, or training to employees who do not have full collective bargaining and representation rights under these chapters. Nothing in this subdivision shall be construed to limit the disclosure duties of a state agency with respect to any other records relating to the activities governed by the employee relations acts referred to in this subdivision.

(q) Records of state agencies related to activities governed by Article 2.6 (commencing with Section 14081), Article 2.8 (commencing with Section 14087.5), and Article 2.91 (commencing with Section 14089) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, that reveal the special negotiator's deliberative processes, discussions, communications, or any other portion of the negotiations with providers of health care services, impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy, or that provide instruction, advice, or training to employees.

Except for the portion of a contract containing the rates of payment, contracts for inpatient services entered into pursuant to these articles, on or after April 1, 1984, shall be open to inspection one year after they are fully executed. In the event that a contract for inpatient services that is entered into prior to April 1, 1984, is amended on or after April 1, 1984,

the amendment, except for any portion containing the rates of payment, shall be open to inspection one year after it is fully executed. If the California Medical Assistance Commission enters into contracts with health care providers for other than inpatient hospital services, those contracts shall be open to inspection one year after they are fully executed.

Three years after a contract or amendment is open to inspection under this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

Notwithstanding any other provision of law, the entire contract or amendment shall be open to inspection by the Joint Legislative Audit Committee and the Legislative Analyst's office. The committee and the office shall maintain the confidentiality of the contracts and amendments until the time a contract or amendment is fully open to inspection by the public.

(r) Records of Native American graves, cemeteries, and sacred places maintained by the Native American Heritage Commission.

(s) A final accreditation report of the Joint Commission on Accreditation of Hospitals that has been transmitted to the State Department of Health Services pursuant to subdivision (b) of Section 1282 of the Health and Safety Code.

(t) Records of a local hospital district, formed pursuant to Division 23 (commencing with Section 32000) of the Health and Safety Code, or the records of a municipal hospital, formed pursuant to Article 7 (commencing with Section 37600) or Article 8 (commencing with Section 37650) of Chapter 5 of Division 3 of Title 4 of this code, that relate to any contract with an insurer or nonprofit hospital service plan for inpatient or outpatient services for alternative rates pursuant to Section 10133 or 11512 of the Insurance Code. However, the record shall be open to inspection within one year after the contract is fully executed.

(u) (1) Information contained in applications for licenses to carry firearms issued pursuant to Section 12050 of the Penal Code by the sheriff of a county or the chief or other head of a municipal police department that indicates when or where the applicant is vulnerable to attack or that concerns the applicant's medical or psychological history or that of members of his or her family.

(2) The home address and telephone number of peace officers, judges, court commissioners, and magistrates that are set forth in applications for licenses to carry firearms issued pursuant to Section 12050 of the Penal Code by the sheriff of a county or the chief or other head of a municipal police department.

(3) The home address and telephone number of peace officers, judges, court commissioners, and magistrates that are set forth in

licenses to carry firearms issued pursuant to Section 12050 of the Penal Code by the sheriff of a county or the chief or other head of a municipal police department.

(v) (1) Records of the Major Risk Medical Insurance Program related to activities governed by Part 6.3 (commencing with Section 12695) and Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with health plans, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

(2) (A) Except for the portion of a contract that contains the rates of payment, contracts for health coverage entered into pursuant to Part 6.3 (commencing with Section 12695) or Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code, on or after July 1, 1991, shall be open to inspection one year after they have been fully executed.

(B) In the event that a contract for health coverage that is entered into prior to July 1, 1991, is amended on or after July 1, 1991, the amendment, except for any portion containing the rates of payment, shall be open to inspection one year after the amendment has been fully executed.

(3) Three years after a contract or amendment is open to inspection pursuant to this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(4) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments thereto, until the contract or amendments to a contract is open to inspection pursuant to paragraph (3).

(w) (1) Records of the Major Risk Medical Insurance Program related to activities governed by Chapter 14 (commencing with Section 10700) of Part 2 of Division 2 of the Insurance Code, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with health plans, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

(2) Except for the portion of a contract that contains the rates of payment, contracts for health coverage entered into pursuant to Chapter 14 (commencing with Section 10700) of Part 2 of Division 2 of the

Insurance Code, on or after January 1, 1993, shall be open to inspection one year after they have been fully executed.

(3) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments thereto, until the contract or amendments to a contract is open to inspection pursuant to paragraph (2).

(x) Financial data contained in applications for registration, or registration renewal, as a service contractor filed with the Director of the Department of Consumer Affairs pursuant to Chapter 20 (commencing with Section 9800) of Division 3 of the Business and Professions Code, for the purpose of establishing the service contractor's net worth, or financial data regarding the funded accounts held in escrow for service contracts held in force in this state by a service contractor.

(y) (1) Records of the Managed Risk Medical Insurance Board related to activities governed by Part 6.2 (commencing with Section 12693) or Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with health plans, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

(2) (A) Except for the portion of a contract that contains the rates of payment, contracts entered into pursuant to Part 6.2 (commencing with Section 12693) or Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code, on or after January 1, 1998, shall be open to inspection one year after they have been fully executed.

(B) In the event that a contract entered into pursuant to Part 6.2 (commencing with Section 12693) or Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code is amended, the amendment shall be open to inspection one year after the amendment has been fully executed.

(3) Three years after a contract or amendment is open to inspection pursuant to this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(4) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments thereto until the contract or amendments to a contract are open to inspection pursuant to paragraph (2) or (3).

(5) The exemption from disclosure provided pursuant to this subdivision for the contracts, deliberative processes, discussions, communications, negotiations with health plans, impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff shall also apply to the contracts, deliberative processes, discussions, communications, negotiations with health plans, impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of applicants pursuant to Part 6.4 (commencing with Section 12699.50) of Division 2 of the Insurance Code.

(z) Records obtained pursuant to paragraph (2) of subdivision (c) of Section 2891.1 of the Public Utilities Code.

(aa) A document prepared by or for a state or local agency that assesses its vulnerability to terrorist attack or other criminal acts intended to disrupt the public agency's operations and that is for distribution or consideration in a closed session.

(bb) (1) Records of the Managed Risk Medical Insurance Board related to activities governed by Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code, and that reveal the deliberative processes, discussions, communications, or any other portion of the negotiations with entities contracting or seeking to contract with the board, or the impressions, opinions, recommendations, meeting minutes, research, work product, theories, or strategy of the board or its staff, or records that provide instructions, advice, or training to employees.

(2) (A) Except for the portion of a contract that contains the rates of payment, contracts entered into pursuant to Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code on or after January 1, 2004, shall be open to inspection one year after they have been fully executed.

(B) In the event that a contract entered into pursuant to Part 8.7 (commencing with Section 2120) of Division 2 of the Labor Code is amended, the amendment shall be open to inspection one year after the amendment has been fully executed.

(3) Three years after a contract or amendment is open to inspection pursuant to this subdivision, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(4) Notwithstanding any other provision of law, the entire contract or amendments to a contract shall be open to inspection by the Joint Legislative Audit Committee. The committee shall maintain the confidentiality of the contracts and amendments thereto until the contract or amendments to a contract are open to inspection pursuant to paragraph (2) or (3).

Nothing in this section prevents any agency from opening its records concerning the administration of the agency to public inspection, unless disclosure is otherwise prohibited by law.

Nothing in this section prevents any health facility from disclosing to a certified bargaining agent relevant financing information pursuant to Section 8 of the National Labor Relations Act.

SEC. 3. Section 1341.4 of the Health and Safety Code is amended to read:

1341.4. (a) In order to effectively support the Department of Managed Care in the administration of this law, there is hereby established in the State Treasury, the Managed Care Fund. The administration of the Department of Managed Care shall be supported from the Managed Care Fund.

(b) For the 2004–05 and 2005–06 fiscal years only, up to three hundred sixty-four thousand dollars ($364,000) from the Managed Care Fund may be used annually to support staff and related functions associated with the California Health Care Quality Improvement and Cost Containment Commission established pursuant to Chapter 8 (commencing with Section 127670) of Part 2 of Division 107.

(c) In any fiscal year, the Managed Care Fund shall maintain not more than a prudent 5 percent reserve unless otherwise determined by the Department of Finance.

SEC. 3.2. Section 1575.5 of the Health and Safety Code is amended to read:

1575.5. (a) Concurrently with the submission of any application under Section 1575.2, the applicant shall apply to the department for eligibility certification as a provider of adult day health care services reimbursable under the Medi-Cal Act (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code). No license shall be issued or renewed for an adult day health care center that is not approved as a Medi-Cal provider of adult day health care services.

(b) (1) This section shall not apply to centers licensed during a moratorium imposed in accordance with Section 14043.46 of the Welfare and Institutions Code. The moratorium shall not prohibit the department from approving a change in ownership, relocation, or increase in capacity for an adult day health care center that meets the conditions in subdivision (c) of Section 14043.46 of the Welfare and Institutions Code.

(2) This section shall not apply upon the implementation of the adult day health care waiver in accordance with the Welfare and Institutions Code.

SEC. 3.5. Section 101315 of the Health and Safety Code is amended to read:

101315. (a) Federal funding received by the State Department of Health Services for bioterrorism preparedness and emergency response is subject to appropriation in the annual Budget Act or other statute, commencing with the 2003–04 fiscal year.

(b) This article shall govern those instances when federal funding is allocated and expended for public health preparedness and response by local health jurisdictions, hospitals, clinics, emergency medical systems, and poison control centers for the prevention of, and response to, bioterrorist attacks and other public health emergencies pursuant to the federally approved collaborative state-local plan.

(c) A local health jurisdiction shall be ineligible to receive funding from appropriations made for purposes of this article when that local health jurisdiction receives directly or through another local jurisdiction federal funding for the same purposes. Moneys appropriated for purposes of this article that would have been allocated to a local health jurisdiction that is ineligible, pursuant to this subdivision, to receive funding shall be allocated, as provided in Section 101317, among the remaining local health jurisdictions that are eligible.

(d) Funds appropriated for the purposes of this article shall not be used to supplant funding for existing levels of service and shall only be used for purposes specified in Section 101317.

(e) This article shall apply only when local health jurisdictions, hospitals, clinics, emergency medical systems, and poison control centers are designated by a federal or state agency to manage the funds for public health preparedness and response to bioterrorist attacks and other public health emergencies, pursuant to the federally approved collaborative state-local plan.

SEC. 3.6. Section 101319 of the Health and Safety Code is amended to read:

101319. Due to the need to rapidly implement, and to provide local health jurisdictions, hospitals, clinics, emergency medical systems, and poison control centers with timely funding for the purposes of, this article, funds appropriated in the annual Budget Act or some other act for purposes of this article for the 2002–03 fiscal year and subsequent fiscal years shall be allocated through the use of agreements, which shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

SEC. 3.7. Section 101320 is added to the Health and Safety Code, to read:

101320. This article shall become inoperative on September 1, 2007, and, as of January 1, 2008, is repealed, unless a later enacted

statute that is enacted before January 1, 2008, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 3.8. Section 101750 of the Health and Safety Code is amended to read:

101750. The authority is hereby declared to be a body corporate and politic and it shall have power:

(a) To have perpetual succession.

(b) To sue and be sued in the name of the authority in all actions and proceedings in all courts and tribunals of competent jurisdiction.

(c) To adopt a seal and alter it at pleasure.

(d) To take by grant, purchase, gift, devise, or lease, to hold, use and enjoy, and to lease, convey or dispose of, real and personal property of every kind, within or without the boundaries of the authority, necessary or convenient to the full exercise of its powers. The board may lease, mortgage, sell, or otherwise dispose of any real or personal property within or without the boundaries of the authority necessary to the full or convenient exercise of its powers.

(e) To make and enter into contracts with any public agency or person for the purposes of this chapter, including, but not limited to, agreements under Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code. Members of the board shall be disqualified from voting on contracts in which they have a financial interest. Notwithstanding any other provision of law, members shall not be disqualified from continuing to serve as a member of the board and a contract may not be avoided solely because of a member's financial interest.

(f) To appoint and employ an executive director and other employees as may be necessary, including legal counsel, fix their compensation and define their powers and duties. The board shall prescribe the amounts and forms of fidelity bond of its officers and employees. The cost of these bonds shall be borne by the authority. The authority may also contract for the services of an independent contractor.

(g) To incur indebtedness not exceeding revenue in any year.

(h) To purchase supplies, equipment, materials, property, or services.

(i) To establish policies relating to its purposes.

(j) To acquire or contract to acquire, rights-of-way, easements, privileges, or property of every kind within or without the boundaries of the authority, and construct, equip, maintain, and operate any and all works or improvements within or without the boundaries of the authority necessary, convenient, or proper to carry out any of the provisions, objects or purposes of this chapter, and to complete, extend, add to, repair, or otherwise improve any works or improvements acquired by it.

(k) To make contracts and enter into stipulations of any nature upon the terms and conditions that the board finds are for the best interest of the authority for the full exercise of the powers granted in this chapter.

(*l*) To accept gifts, contributions, grants or loans from any public agency or person for the purposes of this chapter. The authority may do any and all things necessary in order to avail itself of the gifts, contributions, grants or loans, and cooperate under any federal or state legislation in effect on March 25, 1982 or enacted after that date.

(m) To manage its moneys and to provide depository and auditing services pursuant to either of the methods applicable to special districts as set forth in the Government Code.

(n) To negotiate with service providers rates, charges, fees and rents, and to establish classifications of health care systems operated by the authority. Members of the board who are county officers and employees may vote to approve arrangements and agreements between the authority and the county as a service provider and these directors shall not thus be disqualified solely for the reason that they are employed by the county.

(o) To develop and implement health care delivery systems to promote quality care and cost efficiency and to provide appeal and grievance procedures available to both providers and consumers.

(p) To provide health care delivery systems for any or all of the following:

(1) For all persons who are eligible to receive medical benefits under the Medi-Cal Act, as set forth in Sections 14000 and following, of the Welfare and Institutions Code in the county through waiver, pilot project, or otherwise.

(2) For all persons in the county who are eligible to receive medical benefits under both Titles XVIII and XIX of the federal Social Security Act.

(3) For all persons in the county who are eligible to receive medical benefits under Title XVIII of the federal Social Security Act.

(4) For all persons in the county who are eligible to receive medical benefits under publicly supported programs if the authority, and participating providers acting pursuant to subcontracts with the authority, agree to hold harmless the beneficiaries of the publicly supported programs if the contract between the sponsoring government agency and the authority does not ensure sufficient funding to cover program benefits.

(q) To insure against any accident or destruction of its health care system or any part thereof. It may insure against loss of revenues from any cause. The authority may also provide insurance as provided in Part

6 (commencing with Section 989) of Division 3.6 of Title 1 of the Government Code.

(r) To exercise powers that are expressly granted and powers that are reasonably implied from express powers and necessary to carry out the purposes of this chapter.

(s) To do any and all things necessary to carry out the purposes of this chapter.

SEC. 3.9. Section 101750.5 is added to the Health and Safety Code, to read:

101750.5. Notwithstanding subdivision (f) of Section 14499.5 of the Welfare and Institutions Code, for the purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, the authority shall be considered a public entity separate from the county or counties and shall file the statement required by Section 53051 of the Government Code.

SEC. 4. Section 120956 is added to the Health and Safety Code, to read:

120956. (a) The AIDS Drug Assistance Program Rebate Fund is hereby created as a special fund in the State Treasury.

(b) All rebates collected from drug manufacturers on drugs purchased through the AIDS Drugs Assistance Program (ADAP) implemented pursuant to this chapter and, notwithstanding Section 16305.7 of the Government Code, interest earned on these moneys shall be deposited in the fund exclusively to cover costs related to the purchase of drugs and services provided through ADAP.

(c) Notwithstanding Section 13340 of the Government Code, moneys in the fund shall be continuously appropriated without regard to fiscal year to State Department of Health Services and available for expenditure for those purposes specified under this section.

SEC. 5. Chapter 5 (commencing with Section 123223) is added to Part 1 of Division 106 of the Health and Safety Code, to read:

CHAPTER 5. CHILDREN'S MEDICAL SERVICES REBATE FUND

123223. (a) The Children's Medical Services Rebate Fund is hereby created as a special fund in the State Treasury.

(b) All rebates for the delivery of health care, medical supplies, pharmaceuticals, including blood replacement products, and equipment for clients enrolled in the state funded Genetically Handicapped Person's Program, Chapter 2 (commencing with Section 125125) of Part 5, and the California Children's Services Program, Article 5 (commencing with Section 123800) of Chapter 3 of Part 2, and, notwithstanding Section 16305.7 of the Government Code, interest earned on these

moneys, shall be deposited in the Children's Medical Services Rebate Fund exclusively to cover costs related to services, and the administration of services, provided through the Genetically Handicapped Person's Program and California Children's Services Program.

(c) Notwithstanding Section 13340 of the Government Code, moneys in the Children's Medical Services Rebate Fund shall be continuously appropriated without regard to fiscal year to the State Department of Health Services and available for expenditure for those purposes specified under this section.

SEC. 6. Section 123707 of the Health and Safety Code is amended to read:

123707. (a) The State Department of Health Services may manufacture, test, distribute, and maintain licensure of the product Botulism Immune Globulin Intravenous (Human) if all necessary federal licenses are obtained. The department was issued United States License No. 1622 on October 23, 2003, by the United States Food and Drug Administration under the authority of Section 351(a) of the Public Health Service Act controlling the manufacture and sale of biological products. The product may be labeled with the proprietary name BabyBIG®.

(b) The United States Food and Drug Administration license agreement stipulated the contracts and commodity purchases required to manufacture, test, distribute, and maintain licensure of Botulism Immune Globulin Intravenous (Human). Therefore, contracts and commodity purchases for any manufacture, testing, distribution, packaging, development, and licensure of Botulism Immune Globulin Intravenous (Human) by the department shall be exempt from competitive bidding and shall be exempt from the requirements of Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

(c) Since the incidence of infant botulism in California can vary by as much as 60 percent from year to year, and since continuity of program operations is critical to the health and well-being of these infants, any funds not expended at the end of the fiscal year shall be carried forward into the next fiscal year, notwithstanding any other provision of law.

(d) In carrying out this article, the Infant Botulism Treatment and Prevention Unit may adopt regulations, make and receive grants, and enter into contracts and interagency agreements.

SEC. 6.1. The Legislature finds and declares all of the following:

(a) Birth defects are the leading cause of infant death in California and the United States.

(b) In California, more than 530,000 babies are born each year. According to the California Birth Defects Monitoring Program, one in 33 will be born with a debilitating condition. Of these, one in 11 will die.

(c) Each year, newborn screen programs in all states test four million newborns to identify those who may have specific genetic and metabolic disorders that could threaten their life or long-term health and development. An estimated one in 3,000 newborn children carries a metabolic disorder that interferes with the growing child's development. California conducts newborn screening for the following disorders: phenylketonuria, galactosemia, sickle cell disease, and congenital hypothyroidism. Since 1980, more than 5,500 cases of these disorders have been detected from a small blood sample collected from each newborn shortly after birth. Without early detection and dietary treatment, children affected with these genetic conditions may suffer serious illness, severe physical or developmental disability, and death. The state's newborn screening program has proven effective in reducing the incidence of morbidity and mortality resulting from these four disorders.

(d) Recent technological advances make it possible and affordable to screen for larger numbers of treatable metabolic disorders, more than 20 from a single sample. At least 26 states have implemented this new technology, tandem mass spectrometry. In order to keep pace with the rest of the nation, California needs to expand its newborn screening program.

(e) In 2002–03, the Genetic Disease Branch (GDB) of the State Department of Health Services conducted a pilot project to expand newborn screening to 30 disorders.

(f) According to the Centers for Disease Control and Prevention, the average lifetime cost of providing services to a person with moderate mental retardation is $1,014,000. For every 20 additional cases identified through expanded screening, average lifetime cost savings could exceed $20,000,000. Approximately 38 percent of infants born in California are eligible for Medi-Cal. Thus, significant costs are incurred by the state for providing medical care, special education, developmental services, and physical and speech, or occupational therapies to children with untreated disorders. Health plans, insurance companies, and individual families also incur major costs.

(g) Cost-benefit analyses have repeatedly found that expanded newborn screening produces significant net benefits. The GDB estimates that for every dollar spent on expanded screening, $2.59 is saved in average lifetime costs. Moreover, expanded screening will save lives.

SEC. 6.2. Section 124977 of the Health and Safety Code is amended to read:

124977. (a) It is the intent of the Legislature that, unless otherwise specified, the program carried out pursuant to this chapter be fully supported from fees collected for services provided by the program.

(b) (1) The department shall charge a fee to all payers for any tests or activities performed pursuant to this chapter. The amount of the fee shall be established by regulation and periodically adjusted by the director in order to meet the costs of this chapter. Notwithstanding any other provision of law, any fees charged for prenatal screening and followup services provided to persons enrolled in the Medi-Cal program, health care service plan enrollees, or persons covered by health insurance policies, shall be paid in full directly to the Genetic Disease Testing Fund, subject to all terms and conditions of each enrollee's or insured's health care service plan or insurance coverage, whichever is applicable, including, but not limited to, copayments and deductibles applicable to these services, and only if these copayments, deductibles, or limitations are disclosed to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.

(2) The department shall expeditiously undertake all steps necessary to implement the fee collection process, including personnel, contracts, and data processing, so as to initiate the fee collection process at the earliest opportunity.

(3) The director shall convene, in the most cost-efficient manner and using existing resources, a working group comprised of health insurance, health care service plan, hospital, consumer, and department representatives to evaluate newborn and prenatal screening fee billing procedures, and recommend to the department ways to improve these procedures in order to improve efficiencies and enhance revenue collections for the department and hospitals. In performing its duties, the working group may consider models in other states. The working group shall make its recommendations by March 1, 2005.

(4) Effective for services provided on and after July 1, 2002, the department shall charge a fee to the hospital of birth, or, for births not occurring in a hospital, to families of the newborn, for newborn screening and followup services. The hospital of birth and families of newborns born outside the hospital shall make payment in full to the Genetic Disease Testing Fund. The department shall not charge or bill Medi-Cal beneficiaries for services provided under this chapter.

(c) (1) The Legislature finds that timely implementation of changes in genetic screening programs and continuous maintenance of quality statewide services requires expeditious regulatory and administrative procedures to obtain the most cost-effective electronic data processing,

hardware, software services, testing equipment, and testing and followup services.

(2) The expenditure of funds from the Genetic Disease Testing Fund for these purposes shall not be subject to Section 12102 of, and Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of, the Public Contract Code, or to Division 25.2 (commencing with Section 38070). The department shall provide the Department of Finance with documentation that equipment and services have been obtained at the lowest cost consistent with technical requirements for a comprehensive high-quality program.

(3) The expenditure of funds from the Genetic Disease Testing Fund for implementation of the Tandem Mass Spectrometry screening for fatty acid oxidation, amino acid, and organic acid disorders, and screening for congenital adrenal hyperplasia may be implemented through the amendment of the Genetic Disease Branch Screening Information System contracts and shall not be subject to Chapter 3 (commencing with Section 12100) of Part 2 of Division 2 of the Public Contract Code, Article 4 (commencing with Section 19130) of Chapter 5 of Part 2 of Division 5 of Title 2 of the Government Code, and any policies, procedures, regulations or manuals authorized by those laws.

(d) (1) The department may adopt emergency regulations to implement and make specific this chapter in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. For the purposes of the Administrative Procedure Act, the adoption of regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, these emergency regulations shall not be subject to the review and approval of the Office of Administrative Law. Notwithstanding Section 11346.1 and Section 11349.6 of the Government Code, the department shall submit these regulations directly to the Secretary of State for filing. The regulations shall become effective immediately upon filing by the Secretary of State. Regulations shall be subject to public hearing within 120 days of filing with the Secretary of State and shall comply with Sections 11346.8 and 11346.9 of the Government Code or shall be repealed.

(2) The Office of Administrative Law shall provide for the printing and publication of these regulations in the California Code of Regulations. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the regulations adopted pursuant to this chapter shall not be repealed by the

Office of Administrative Law and shall remain in effect until revised or repealed by the department.

(3) The Legislature finds and declares that the health and safety of California newborns is in part dependent on an effective and adequately staffed genetic disease program, the cost of which shall be supported by the fees generated by the program.

SEC. 6.3. Section 124980 of the Health and Safety Code is amended to read:

124980. The director shall establish any regulations and standards for hereditary disorders programs as the director deems necessary to promote and protect the public health and safety. Standards shall include licensure of master level genetic counselors and doctoral level geneticists. Regulations adopted shall implement the principles established in this section. These principles shall include, but not be limited to, the following:

(a) The public, especially communities and groups particularly affected by programs on hereditary disorders, should be consulted before any regulations and standards are adopted by the department.

(b) The incidence, severity, and treatment costs of each hereditary disorder and its perceived burden by the affected community should be considered and, where appropriate, state and national experts in the medical, psychological, ethical, social, and economic effects or programs for the detection and management of hereditary disorders shall be consulted by the department.

(c) Information on the operation of all programs on hereditary disorders within the state, except for confidential information obtained from participants in the programs, shall be open and freely available to the public.

(d) Clinical testing procedures established for use in programs, facilities, and projects shall be accurate, provide maximum information, and the testing procedures selected shall produce results that are subject to minimum misinterpretation.

(e) No test or tests may be performed on any minor over the objection of the minor's parents or guardian, nor may any tests be performed unless the parent or guardian is fully informed of the purposes of testing for hereditary disorders and is given reasonable opportunity to object to the testing.

(f) No testing, except initial screening for phenylketonuria (PKU) and other diseases that may be added to the newborn screening program, shall require mandatory participation, and no testing programs shall require restriction of childbearing, and participation in a testing program shall not be a prerequisite to eligibility for, or receipt of, any other service or assistance from, or to participate in, any other program, except where

necessary to determine eligibility for further programs of diagnoses of or therapy for hereditary conditions.

(g) Pretest and posttest counseling services for hereditary disorders shall be available through the program or a referral source for all persons determined to be or who believe themselves to be at risk for a hereditary disorder. Genetic counseling shall be provided by a physician, a certified advanced practice nurse with a genetics specialty, or other appropriately trained licensed health care professional and shall be nondirective, shall emphasize informing the client, and shall not require restriction of childbearing.

(h) All participants in programs on hereditary disorders shall be protected from undue physical and mental harm, and except for initial screening for phenylketonuria (PKU) and other diseases that may be added to newborn screening programs, shall be informed of the nature of risks involved in participation in the programs, and those determined to be affected with genetic disease shall be informed of the nature, and where possible the cost, of available therapies or maintenance programs, and shall be informed of the possible benefits and risks associated with these therapies and programs.

(i) All testing results and personal information generated from hereditary disorders programs shall be made available to an individual over 18 years of age, or to the individual's parent or guardian. If the individual is a minor or incompetent, all testing results that have positively determined the individual to either have, or be a carrier of, a hereditary disorder shall be given through a physician or other source of health care.

(j) All testing results and personal information from hereditary disorders programs obtained from any individual, or from specimens from any individual, shall be held confidential and be considered a confidential medical record except for information that the individual, parent, or guardian consents to be released, provided that the individual is first fully informed of the scope of the information requested to be released, of all of the risks, benefits, and purposes for the release, and of the identity of those to whom the information will be released or made available, except for data compiled without reference to the identity of any individual, and except for research purposes, provided that pursuant to Subpart A (commencing with Section 46.101) of Part 46 of Title 45 of the Code of Federal Regulations entitled ''Basic HHS Policy for Protection of Human Subjects,'' the research has first been reviewed and approved by an institutional review board that certifies the approval to the custodian of the information and further certifies that in its judgment the information is of such potentially substantial public health value that

modification of the requirement for legally effective prior informed consent of the individual is ethically justifiable.

(k) A physician providing information to patients on expanded newborn screening shall disclose to the parent the physician's financial interest, if any, in the laboratory to which the patient is being referred.

(*l*) An individual whose confidentiality has been breached as a result of any violation of the provisions of the Hereditary Disorders Act, as defined in subdivision (b) of Section 27, may recover compensatory and civil damages. Any person who negligently breaches the confidentiality of an individual tested under this article shall be subject to civil damages of not more than ten thousand dollars ($10,000), reasonable attorney's fees, and the costs of litigation. Any person who knowingly breaches the confidentiality of an individual tested under this article shall be subject to payment of compensatory damages, and in addition, may be subject to civil damages of fifty thousand dollars ($50,000), reasonable attorney's fees, and the costs of litigation, or imprisonment in the county jail of not more than one year. If the offense is committed under false pretenses, the person may be subject to a fine of not more than one hundred thousand dollars ($100,000), imprisonment in the county jail of not more than one year, or both. If the offense is committed with the intent to sell, transfer, or use individually identifiable health information for commercial advantage, personal gain, or malicious harm, the person may be subject to a fine of not more than two hundred fifty thousand dollars ($250,000), imprisonment in the county jail of not more than one year, or both.

(m) ''Genetic counseling'' as used in this section shall not include communications that occur between patients and appropriately trained and competent licensed health care professionals, such as physicians, registered nurses, and physicians assistants who are operating within the scope of their license and qualifications as defined by their licensing authority.

SEC. 6.4. Section 125000 of the Health and Safety Code is amended to read:

125000. (a) It is the policy of the State of California to make every effort to detect, as early as possible, phenylketonuria and other preventable heritable or congenital disorders leading to mental retardation or physical defects.

The department shall establish a genetic disease unit, that shall coordinate all programs of the department in the area of genetic disease. The unit shall promote a statewide program of information, testing, and counseling services and shall have the responsibility of designating tests and regulations to be used in executing this program.

The information, tests, and counseling for children shall be in accordance with accepted medical practices and shall be administered to each child born in California once the department has established appropriate regulations and testing methods. The information, tests, and counseling for pregnant women shall be in accordance with accepted medical practices and shall be offered to each pregnant woman in California once the department has established appropriate regulations and testing methods. These regulations shall follow the standards and principles specified in Section 124980. The department may provide laboratory testing facilities or contract with any laboratory that it deems qualified to conduct tests required under this section. However, notwithstanding Section 125005, provision of laboratory testing facilities by the department shall be contingent upon the provision of funding therefor by specific appropriation to the Genetic Disease Testing Fund enacted by the Legislature. If moneys appropriated for purposes of this section are not authorized for expenditure to provide laboratory facilities, the department may nevertheless contract to provide laboratory testing services pursuant to this section and shall perform laboratory services, including, but not limited to, quality control, confirmatory, and emergency testing, necessary to ensure the objectives of this program.

(b) The department shall charge a fee for any tests performed pursuant to this section. The amount of the fee shall be established and periodically adjusted by the director in order to meet the costs of this section.

(c) The department shall inform all hospitals or physicians and surgeons, or both, of required regulations and tests and may alter or withdraw any of these requirements whenever sound medical practice so indicates. To the extent practicable, the department shall provide notice to hospitals and other payers in advance of any increase in the fees charged for the program.

(d) This section shall not apply if a parent or guardian of the newborn child objects to a test on the ground that the test conflicts with his or her religious beliefs or practices.

(e) The genetic disease unit is authorized to make grants or contracts or payments to vendors approved by the department for all of the following:

(1) Testing and counseling services.

(2) Demonstration projects to determine the desirability and feasibility of additional tests or new genetic services.

(3) To initiate the development of genetic services in areas of need.

(4) To purchase or provide genetic services from any sums as are appropriated for this purpose.

(f) The genetic disease unit shall evaluate and prepare recommendations on the implementation of tests for the detection of hereditary and congenital diseases, including, but not limited to, biotinidase deficiency and cystic fibrosis. The genetic disease unit shall also evaluate and prepare recommendations on the availability and effectiveness of preventative followup interventions, including the use of specialized medically necessary dietary products.

It is the intent of the Legislature that funds for the support of the evaluations and recommendations required pursuant to this subdivision, and for the activities authorized pursuant to subdivision (e), shall be provided in the annual Budget Act appropriation from the Genetic Disease Testing Fund.

(g) Health care providers that contract with a prepaid group practice health care service plan that annually has at least 20,000 births among its membership, may provide, without contracting with the department, any or all of the testing and counseling services required to be provided under this section or the regulations adopted pursuant thereto, if the services meet the quality standards and adhere to the regulations established by the department and the plan pays that portion of a fee established under this section that is directly attributable to the department's cost of administering the testing or counseling service and to any required testing or counseling services provided by the state for plan members. The payment by the plan, as provided in this subdivision, shall be deemed to fulfill any obligation the provider or the provider's patient may have to the department to pay a fee in connection with the testing or counseling service.

(h) The department may appoint experts in the area of genetic screening, including, but not limited to, cytogenetics, molecular biology, prenatal, specimen collection, and ultrasound to provide expert advice and opinion on the interpretation and enforcement of regulations adopted pursuant to this section. These experts shall be designated agents of the state with respect to their assignments. These experts shall receive no salary, but shall be reimbursed for expenses associated with the purposes of this section. All expenses of the experts for the purposes of this section shall be paid from the Genetic Disease Testing Fund.

SEC. 6.5. Section 125001 of the Health and Safety Code is amended to read:

125001. (a) The department shall establish a program for the development, provision, and evaluation of genetic disease testing, and may provide laboratory testing facilities or make grants to, contract with, or make payments to, any laboratory that it deems qualified and cost-effective to conduct testing or with any metabolic specialty clinic to provide necessary treatment with qualified specialists. The program

shall provide genetic screening and followup services for persons who have the screening.

(b) The department shall expand statewide screening of newborns to include tandem mass spectrometry screening for fatty acid oxidation, amino acid, and organic acid disorders and congenital adrenal hyperplasia as soon as possible. The department shall provide information with respect to these disorders and testing resources available, to all women receiving prenatal care and to all women admitted to a hospital for delivery. If the department is unable to provide this statewide screening by July 1, 2005, the department shall temporarily obtain these testing services through a competitive bid process from one or more public or private laboratories that meet the department's requirements for testing, quality assurance, and reporting. If the department determines that contracting for these services is more cost-effective, and meets the other requirements of this chapter, than purchasing the tandem mass spectrometry equipment themselves, the department shall contract with one or more public or private laboratories.

(c) The department shall report to the Legislature regarding the progress of the program on or before July 1, 2006. The report shall include the costs for screening, followup, and treatment as compared to costs and morbidity averted for each condition tested for in the program.

SEC. 7. Section 127671 of the Health and Safety Code is amended to read:

127671. (a) The Governor shall convene the California Health Care Quality Improvement and Cost Containment Commission, hereinafter referred to as ''the commission,'' to research and recommend appropriate and timely strategies for promoting high quality care and containing health care costs.

(b) The commission shall be composed of 27 members who are knowledgeable about the health care system and health care spending.

(c) The Governor shall appoint 17 members of the commission, as follows:

(1) Three representatives of California's business community, including at least one representative from a small business.

(2) Two representatives from organized labor, one of whom represents health care workers.

(3) Two representatives of consumers.

(4) Two health care practitioners, including at least one physician.

(5) One representative of the disabilities community.

(6) One hospital industry representative.

(7) One pharmaceutical industry representative.

(8) Two representatives of the health insurance industry, one with expertise in managed health care delivery systems and one with expertise in health insurance underwriting and rating.

(9) One representative of academic or health care policy research institutions.

(10) One health care economist.

(11) One expert in disease management techniques and wellness programs.

(d) The Senate Committee on Rules shall appoint four members, with two members from the majority party and two from the minority party.

(e) The Speaker of the Assembly shall appoint four members, of which two members shall be the Chair and Vice Chair of the Assembly Committee on Health.

(f) The Secretary of the Health and Human Services Agency and the Director of the Department of Managed Health Care shall serve as members of the commission.

(g) The Governor shall appoint the chairperson of the commission.

(h) The commission shall, on or before January 1, 2006, issue a report to the Legislature and the Governor making recommendations for health care quality improvement and cost containment. The commission shall, at a minimum, examine and address the following issues:

(1) Assessing California health care needs and available resources.

(2) Lowering the cost of health care coverage.

(3) Increasing patient choices of health coverage options and providers.

(4) Improving the quality of health care.

(5) Increasing the transparency of health care costs and the relative efficiency with which care is delivered.

(6) Potential for integration with workers' compensation insurance.

(7) Use of disease management, wellness, prevention, and other innovative programs to keep people healthy while reducing costs and improving health outcomes.

(8) Consolidation of existing state programs to achieve efficiencies where possible.

(9) Efficient utilization of prescription drugs and technology.

(i) Notwithstanding any other provision of law, the members of the task force shall receive no per diem or travel expense reimbursement, or any other expense reimbursement.

SEC. 7.3. Section 12693.43 of the Insurance Code is amended to read:

12693.43. (a) Applicants applying to the purchasing pool shall agree to pay family contributions, unless the applicant has a family

contribution sponsor. Family contribution amounts consist of the following two components:

(1) The flat fees described in subdivision (b) or (d).

(2) Any amounts that are charged to the program by participating health, dental, and vision plans selected by the applicant that exceed the cost to the program of the highest cost Family Value Package in a given geographic area.

(b) In each geographic area, the board shall designate one or more Family Value Packages for which the required total family contribution is:

(1) Seven dollars ($7) per child with a maximum required contribution of fourteen dollars ($14) per month per family for applicants with annual household incomes up to and including 150 percent of the federal poverty level.

(2) Nine dollars ($9) per child with a maximum required contribution of twenty-seven dollars ($27) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 200 percent of the federal poverty level and for applicants on behalf of children described in clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70.

(3) On and after July 1, 2005, fifteen dollars ($15) per child with a maximum required contribution of forty-five dollars ($45) per month per family for applicants with annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable. Notwithstanding any other provision of law, if an application with an effective date prior to July 1, 2005, was based on annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable, then this subparagraph shall be applicable to the applicant on July 1, 2005, unless subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income. The program shall provide prior notice to any applicant for currently enrolled subscribers whose premium will increase on July 1, 2005, pursuant to this subparagraph and, prior to the date the premium increase takes effect, shall provide that applicant with an opportunity to demonstrate that subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income.

(c) Combinations of health, dental, and vision plans that are more expensive to the program than the highest cost Family Value Package may be offered to and selected by applicants. However, the cost to the program of those combinations that exceeds the price to the program of the highest cost Family Value Package shall be paid by the applicant as part of the family contribution.

(d) The board shall provide a family contribution discount to those applicants who select the health plan in a geographic area that has been designated as the Community Provider Plan. The discount shall reduce the portion of the family contribution described in subdivision (b) to the following:

(1) A family contribution of four dollars ($4) per child with a maximum required contribution of eight dollars ($8) per month per family for applicants with annual household incomes up to and including 150 percent of the federal poverty level.

(2) Six dollars ($6) per child with a maximum required contribution of eighteen dollars ($18) per month per family for applicants with annual household incomes greater than 150 percent and up to and including 200 percent of the federal poverty level and for applicants on behalf of children described in clause (ii) of subparagraph (A) of paragraph (6) of subdivision (a) of Section 12693.70.

(3) On and after July 1, 2005, twelve dollars ($12) per child with a maximum required contribution of thirty-six dollars ($36) per month per family for applicants with annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable. Notwithstanding any other provision of law, if an application with an effective date prior to July 1, 2005, was based on annual household income to which subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is applicable, then this subparagraph shall be applicable to the applicant on July 1, 2005, unless subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income. The program shall provide prior notice to any applicant for currently enrolled subscribers whose premium will increase on July 1, 2005, pursuant to this subparagraph and, prior to the date the premium increase takes effect, shall provide that applicant with an opportunity to demonstrate that subparagraph (B) of paragraph (6) of subdivision (a) of Section 12693.70 is no longer applicable to the relevant family income.

(e) Applicants, but not family contribution sponsors, who pay three months of required family contributions in advance shall receive the fourth consecutive month of coverage with no family contribution required.

(f) Applicants, but not family contribution sponsors, who pay the required family contributions by an approved means of electronic fund transfer shall receive a 25-percent discount from the required family contributions.

(g) It is the intent of the Legislature that the family contribution amounts described in this section comply with the premium cost sharing limits contained in Section 2103 of Title XXI of the Social Security Act.

If the amounts described in subdivision (a) are not approved by the federal government, the board may adjust these amounts to the extent required to achieve approval of the state plan.

(h) The adoption and one readoption of regulations to implement paragraph (3) of subdivision (b) and paragraph (3) of subdivision (d) shall be deemed to be an emergency and necessary for the immediate preservation of public peace, health, and safety, or general welfare for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the board is hereby exempted from the requirement that it describe specific facts showing the need for immediate action and from review by the Office of Administrative Law. For purpose of subdivision (e) of Section 11346.1 of the Government code, the 120-day period, as applicable to the effective period of an emergency regulatory action and submission of specified materials to the Office of Administrative law, is hereby extended to 180 days.

SEC. 7.5. Section 12699.10 of the Insurance Code is repealed.

SEC. 8. Section 4094.2 of the Welfare and Institutions Code is amended to read:

4094.2. (a) For the purpose of establishing payment rates for community treatment facility programs, the private nonprofit agencies selected to operate these programs shall prepare a budget that covers the total costs of providing residential care and supervision and mental health services for their proposed programs. These costs shall include categories that are allowable under California's Foster Care program and existing programs for mental health services. They shall not include educational, nonmental health medical, and dental costs.

(b) Each agency operating a community treatment facility program shall negotiate a final budget with the local mental health department in the county in which its facility is located (the host county) and other local agencies, as appropriate. This budget agreement shall specify the types and level of care and services to be provided by the community treatment facility program and a payment rate that fully covers the costs included in the negotiated budget. All counties that place children in a community treatment facility program shall make payments using the budget agreement negotiated by the community treatment facility provider and the host county.

(c) A foster care rate shall be established for each community treatment facility program by the State Department of Social Services. These rates shall be established using the existing foster care ratesetting system for group homes, with modifications designed as necessary. It is anticipated that all community treatment facility programs will offer the level of care and services required to receive the highest foster care rate provided for under the current group home ratesetting system.

(d) For the 2001–02 fiscal year, the 2002–03 fiscal year, the 2003–04 fiscal year, and the 2004–05 fiscal year, community treatment facility programs shall also be paid a community treatment facility supplemental rate of up to two thousand five hundred dollars ($2,500) per child per month on behalf of children eligible under the foster care program and children placed out of home pursuant to an individualized education program developed under Section 7572.5 of the Government Code. Subject to the availability of funds, the supplemental rate shall be shared by the state and the counties. Counties shall be responsible for paying a county share of cost equal to 60 percent of the community treatment rate for children placed by counties in community treatment facilities and the state shall be responsible for 40 percent of the community treatment facility supplemental rate. The community treatment facility supplemental rate is intended to supplement, and not to supplant, the payments for which children placed in community treatment facilities are eligible to receive under the foster care program and the existing programs for mental health services.

(e) For initial ratesetting purposes for community treatment facility funding, the cost of mental health services shall be determined by deducting the foster care rate and the community treatment facility supplemental rate from the total allowable cost of the community treatment facility program. Payments to certified providers for mental health services shall be based on eligible services provided to children who are Medi-Cal beneficiaries, up to the statewide maximum allowances for these services.

(f) The department shall provide the community treatment facility supplemental rates to the counties for advanced payment to the community treatment facility providers in the same manner as the regular foster care payment and within the same required payment time limits.

(g) In order to facilitate the study of the costs of community treatment facilities, licensed community treatment facilities shall provide all documents regarding facility operations, treatment, and placements requested by the department.

(h) It is the intent of the Legislature that the department and the State Department of Social Services work to maximize federal financial participation in funding for children placed in community treatment facilities through funds available pursuant to Titles IV-E and XIX of the federal Social Security Act (Title 42 U.S.C. Sec. 670 and following and Sec. 1396 and following) and other appropriate federal programs.

(i) The department and the State Department of Social Services may adopt emergency regulations necessary to implement joint protocols for the oversight of community treatment facilities, to modify existing

licensing regulations governing reporting requirements and other procedural and administrative mandates to take into account the seriousness and frequency of behaviors that are likely to be exhibited by the seriously emotionally disturbed children placed in community treatment facility programs, to modify the existing foster care ratesetting regulations, and to pay the community treatment facility supplemental rate. The adoption of these regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, and general welfare. The regulations shall become effective immediately upon filing with the Secretary of State. The regulations shall not remain in effect more than 180 days unless the adopting agency complies with all the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, as required by subdivision (e) of Section 11346.1 of the Government Code.

SEC. 8.1. Section 4631.5 of the Welfare and Institutions Code is amended to read:

4631.5. (a) The Legislature finds and declares both of the following:

(1) The state is facing a fiscal crisis that will require an unallocated reduction in the 2004–05 fiscal year for regional centers' purchase of service budgets of seven million dollars ($7,000,000).

(2) Even when the state faces an unprecedented fiscal crisis, the services and supports set forth in the Lanterman Developmental Disabilities Services Act (Division 4.5 (commencing with Section 4500)) shall continue to be provided to individuals with developmental disabilities in accordance with state and federal statutes, regulations, and case law, including Association for Retarded Citizens v. Department of Developmental Services (1985) 38 Cal.3d 384.

(b) It is the intent of the Legislature that actions taken pursuant to this section shall not eliminate an individual's eligibility, adversely affect an individual's health and safety, or interfere with an individual's rights as described in Section 4502.

(c) In order to ensure that services to eligible consumers are available throughout the fiscal year, regional centers shall administer their contracts within the level of funding appropriated by the annual Budget Act.

(d) Within 30 days of the enactment of the annual Budget Act, and after consultation with stakeholder organizations, the department shall determine the amount of unallocated reduction that each regional center shall make in its purchase-of-service budget and shall provide each regional center with guidelines, technical assistance, and a variety of options for reducing operations and purchase of service costs.

(e) Within 60 days of the enactment of the annual Budget Act, each regional center shall develop and submit a plan to the department describing in detail how it intends to absorb the unallocated reduction and achieve savings necessary to provide services to eligible consumers throughout the fiscal year within the limitations of the funds allocated. Prior to adopting the plan, each regional center shall hold a public hearing in order to receive comment on the plan. The regional center shall provide notice to the community at least 10 days in advance of the public hearing. The regional center shall summarize and respond to the public testimony in its plan.

(f) A regional center shall implement components of its plans upon approval of the department. Within 30 days of receipt of the plan, the department shall review and approve, or require modification of, portions of the regional center's plan.

(g) This section shall become inoperative on July 1, 2006, and, as of January 1, 2007, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2007, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 8.2. Section 4643 of the Welfare and Institutions Code is amended to read:

4643. (a) If assessment is needed, prior to July 1, 2005, the assessment shall be performed within 120 days following initial intake. Assessment shall be performed as soon as possible and in no event more than 60 days following initial intake where any delay would expose the client to unnecessary risk to his or her health and safety or to significant further delay in mental or physical development, or the client would be at imminent risk of placement in a more restrictive environment. Assessment may include collection and review of available historical diagnostic data, provision or procurement of necessary tests and evaluations, and summarization of developmental levels and service needs and is conditional upon receipt of the release of information specified in subdivision (b). On and after July 1, 2005, the assessment shall be performed within 60 days following intake and if unusual circumstances prevent the completion of assessment within 60 days following intake, this assessment period may be extended by one 30-day period with the advance written approval of the department.

(b) In determining if an individual meets the definition of developmental disability contained in subdivision (a) of Section 4512, the regional center may consider evaluations and tests, including, but not limited to, intelligence tests, adaptive functioning tests, neurological and neuropsychological tests, diagnostic tests performed by a physician, psychiatric tests, and other tests or evaluations that have been performed by, and are available from, other sources.

SEC. 8.3. Section 4648.4 of the Welfare and Institutions Code is amended to read:

4648.4. Notwithstanding any other provision of law or regulation, during the 2004–05 fiscal year, no regional center may pay any provider of the following services or supports a rate that is greater than the rate that is in effect on or after June 30, 2004, unless the increase is required by a contract between the regional center and the vendor that is in effect on June 30, 2004, or the regional center demonstrates that the approval is necessary to protect the consumer's health or safety and the department has granted prior written authorization:

(a) Supported living services.
(b) Transportation, including travel reimbursement.
(c) Socialization training programs.
(d) Behavior intervention training.
(e) Community integration training programs.
(f) Community activities support services.
(g) Mobile day programs.
(h) Creative art programs.
(i) Supplemental day services program supports.
(j) Adaptive skills trainers.
(k) Independent living specialists.

SEC. 8.4. Section 4681.5 of the Welfare and Institutions Code is amended to read:

4681.5. Notwithstanding any other provision of law or regulation, during the 2004–05 fiscal year, no regional center may approve any service level for a residential service provider, as defined in Section 56005 of Title 17 of the California Code of Regulations, if the approval would result in an increase in the rate to be paid to the provider that is greater than the rate that is in effect on or after June 30, 2004, unless the regional center demonstrates to the department that the approval is necessary to protect the consumer's health or safety and the department has granted prior written authorization.

SEC. 8.5. Section 4691.6 of the Welfare and Institutions Code is amended to read:

4691.6. (a) Notwithstanding any other provision of law or regulation, during the 2004–05 fiscal year, the department may not establish any permanent payment rate for a community-based day program or in-home respite service agency provider that has a temporary payment rate in effect on June 30, 2004, if the permanent payment rate would be greater than the temporary payment rate in effect on or after June 30, 2004, unless the regional center demonstrates to the department that the permanent payment rate is necessary to protect the consumers' health or safety.

(b) Notwithstanding any other provision of law or regulation, during the 2004–05 fiscal year, neither the department nor any regional center may approve any program design modification or revendorization for a community-based day program or in-home respite service agency provider that would result in an increase in the rate to be paid to the vendor from the rate that is in effect on or after June 30, 2004, unless the regional center demonstrates that the program design modification or revendorization is necessary to protect the consumers' health or safety and the department has granted prior written authorization.

(c) Notwithstanding any other provision of law or regulation, during the 2004–05 fiscal year, the department may not approve an anticipated rate adjusted for a community-based day program or in-home respite service agency provider that would result in an increase in the rate to be paid to the vendor from the rate that is in effect on or after June 30, 2004, unless the regional center demonstrates that the anticipated rate adjustment is necessary to protect the consumers' health or safety.

(d) Notwithstanding any other provision of law or regulation, during the 2004–05 fiscal year, the department may not approve any rate adjustment for a habilitation services program that would result in an increase in the rate to be paid to the vendor from the rate that is in effect on or after June 30, 2004, unless the regional center demonstrates that the rate adjustment is necessary to protect the consumers' health and safety and the department has granted prior written authorization.

SEC. 8.6. Section 4781.5 of the Welfare and Institutions Code is amended to read:

4781.5. For the 2004–05 and 2005–06 fiscal years only, a regional center may not expend any purchase of service funds for the startup of any new program unless the expenditure is necessary to protect the consumer's health or safety or because of other extraordinary circumstances, and the department has granted prior written authorization for the expenditure. This provision shall not apply to any of the following:

(a) The purchase of services funds allocated as part of the department's community placement plan process.

(b) Expenditures for the startup of new programs made pursuant to a contract entered into before July 1, 2002.

SEC. 9. Section 4783 is added to the Welfare and Institutions Code, to read:

4783. (a) (1) The Family Cost Participation Program is hereby created in the State Department of Developmental Services for the purpose of assessing a cost participation to parents, as defined in Section 50215 of Title 17 of the California Code of Regulations, who have a child to whom all of the following applies:

(A) The child has a developmental disability.

(B) The child is three years of age through 17 years of age.

(C) The child lives in the parents' home.

(D) The child receives services and supports purchased through the regional center.

(E) The child is not eligible for Medi-Cal.

(2) Notwithstanding any other provision of law, a parent described in subdivision (a) shall participate in the Family Cost Participation Program established pursuant to this section.

(b) (1) The department shall develop and establish a Family Cost Participation Schedule that shall be used by regional centers to assess the parents' cost participation. The schedule shall consist of a sliding scale for families with an annual gross income not less than 400 percent of the federal poverty guideline, and be adjusted for the level of annual gross income and the number of persons living in the family home.

(2) The schedule established pursuant to this section shall be exempt from the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(c) Family cost participation assessments shall only be applied to respite, day care, and camping services that are included in the child's individual program plan.

(d) If there is more than one minor child living in the parents' home and receiving services or supports paid for by the regional center, or living in a 24-hour out-of-home facility, including a developmental center, the assessed amount shall be adjusted as follows:

(1) A parent that meets the criteria specified in subdivision (b) with two children shall be assessed at 75 percent of the respite, day care, and camping services in each child's individual program plan for each child living at home.

(2) A parent that meets the criteria specified in subdivision (b) with three children shall be assessed at 50 percent of the respite, day care, and camping services included in each child's individual program plan for each child living at home.

(3) A parent that meets the criteria specified in subdivision (b) with four children shall be assessed 25 percent of the respite, day care, and camping services included in each child's individual program plan for each child living at home.

(4) A parent that meets the criteria specified in subdivision (b) with more than four children shall be exempt from participation in the Family Cost Participation Program.

(e) For each child, the amount of cost participation shall be less than the amount of the parental fee that the parent would pay if the child lived in a 24-hour, out-of-home facility.

(f) Commencing January 1, 2005, each regional center shall be responsible for administering the Family Cost Participation Program.

(g) Family cost participation assessments or reassessments shall be conducted as follows:

(1) (A) By December 31, 2005, a regional center shall assess the cost participation for all parents of current consumers who meet the criteria specified in this section. A regional center shall use the most recent individual program plan for this purpose.

(B) A regional center shall assess the cost participation for parents of newly identified consumers at the time of the initial individual program plan.

(C) Reassessments for cost participation shall be conducted as part of the individual program plan review pursuant to subdivision (b) of Section 4646.

(D) The parents are responsible for notifying the regional center when a change in family income occurs that would result in a change in the assessed amount of cost participation.

(2) Parents shall self-certify their gross annual income to the regional center by providing copies of W-2 Wage Earners Statements, payroll stubs, a copy of the prior year's state income tax return, or other documents and proof of other income.

(3) A regional center shall notify parents of the parents' assessed cost participation within 10 working days of receipt of the parents' complete income documentation.

(4) Parents who have not provided copies of income documentation pursuant to paragraph (2) shall be assessed the maximum cost participation based on the highest income level adjusted for family size until such time as the appropriate income documentation is provided. Parents who subsequently provide income documentation that results in a reduction in their cost participation shall be reimbursed for the actual cost difference incurred for services identified in the individual program plan for respite, day care, and camping services, for 90 calendar days preceding the reassessment. The actual cost difference is the difference between the maximum cost participation originally assessed and the reassessed amount using the parents' complete income documentation, that is substantiated with receipts showing that the services have been purchased by the parents.

(5) The executive director of the regional center may grant a cost participation adjustment for parents who incur an unavoidable and uninsured catastrophic loss with direct economic impact on the family or who substantiate, with receipts, significant unreimbursed medical costs associated with care for a child who is a regional center consumer.

A redetermination of the cost participation adjustment shall be made at least annually.

(h) A provider of respite, day care, or camping services shall not charge a rate for the parents' share of cost that is higher than the rate paid by the regional center for its share of cost.

(i) The department shall develop, and regional centers shall use, all forms and documents necessary to administer the program established pursuant to this section. The forms and documents shall be posted on the department's Web site. A regional center shall provide appropriate materials to parents at the initial individual program plan meeting and subsequent individual program plan review meetings. These materials shall include a description of the Family Cost Participation Program.

(j) The department shall include an audit of the Family Cost Participation Program during its audit of a regional center.

(k) (1) Parents may appeal an error in the amount of the parents' cost participation to the executive director of the regional center within 30 days of notification of the amount of the assessed cost participation. The parents may appeal to the Director of Developmental Services, or his or her designee, any decision by the executive director made pursuant to this subdivision within 15 days of receipt of the written decision of the executive director.

(2) Parents who dispute the decision of the executive director pursuant to paragraph (5) of subdivision (g) shall have a right to a fair hearing as described in, and the regional center shall provide notice pursuant to, Chapter 7 (commencing with Section 4700). This paragraph shall become inoperative on July 1, 2006.

(3) On and after July 1, 2006, a parent described in paragraph (2) shall have the right to appeal the decision of the executive director to the Director of Developmental Services, or his or her designee, within 15 days of receipt of the written decision of the executive director.

(*l*) The department may adopt emergency regulations to implement this section. The adoption, amendment, repeal, or readoption of a regulation authorized by this section is deemed to be necessary for the immediate preservation of the public peace, health and safety, or general welfare, for purposes of Sections 11346.1 and 11349.6 of the Government Code, and the department is hereby exempted from the requirement that it describe specific facts showing the need for immediate action. A certificate of compliance for these implementing regulations shall be filed within 24 months following the adoption of the first emergency regulations filed pursuant to this subdivision.

(m) By April 1, 2005, and annually thereafter, the department shall report to the appropriate fiscal and policy committees of the Legislature on the status of the implementation of the Family Cost Participation

Program established under this section. On and after April 1, 2006, the report shall contain all of the following:

(1) The annual total purchase of services savings attributable to the program per regional center.

(2) The annual costs to the department and each regional center to administer the program.

(3) The number of families assessed a cost participation per regional center.

(4) The number of cost participation adjustments granted pursuant to paragraph (5) of subdivision (g) per regional center.

(5) The number of appeals filed pursuant to subdivision (k) and the number of those appeals granted, modified, or denied.

(n) This section shall become inoperative on July 1, 2009, and, as of January 1, 2010, is repealed, unless a later enacted statute, that becomes operative on or before January 1, 2010, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 9.4. Section 4865.1 is added to the Welfare and Institutions Code, to read:

4865.1. (a) A regional center shall continue to pay the rate in effect as of June 30, 2004, for a supported employment placement group composed of a coach-to-client ratio of 1:3 when the provider submits to the State Department of Developmental Services and the regional center, by July 30, 2004, documentation that all of the following conditions apply:

(1) The group was established prior to July 1, 2002.

(2) The group was at the 1:3 ratio on May 1, 2004.

(3) The employer will only accommodate a group of three.

(b) In consultation with the regional center, the State Department of Developmental Services shall determine whether the requirements of this section have been met. The department's decision shall be final.

(c) Groups paid under this section shall meet the requirements of subdivision (r) of Section 4851 by July 1, 2005, or be subject to termination of funding pursuant to subdivision (b) of Section 4860.

SEC. 9.5. Section 5775 of the Welfare and Institutions Code is amended to read:

5775. (a) Notwithstanding any other provision of state law, the State Department of Mental Health shall implement managed mental health care for Medi-Cal beneficiaries through fee-for-service or capitated rate contracts with mental health plans, including individual counties, counties acting jointly, any qualified individual or organization, or a nongovernmental entity. A contract may be exclusive and may be awarded on a geographic basis.

(b) Two or more counties acting jointly may agree to deliver or subcontract for the delivery of mental health services. The agreement may encompass all or any portion of the mental health services provided pursuant to this part. This agreement shall not relieve the individual counties of financial responsibility for providing these services. Any agreement between counties shall delineate each county's responsibilities and fiscal liability.

(c) The department shall offer to contract with each county for the delivery of mental health services to that county's Medi-Cal beneficiary population prior to offering to contract with any other entity, upon terms at least as favorable as any offered to a noncounty contract provider. If a county elects not to contract with the department, does not renew its contract, or does not meet the minimum standards set by the department, the department may elect to contract with any other governmental or nongovernmental entity for the delivery of mental health services in that county and may administer the delivery of mental health services until a contract for a mental health plan is implemented. The county may not subsequently contract to provide mental health services under this part unless the department elects to contract with the county.

(d) If a county does not contract with the department to provide mental health services, the county shall transfer the responsibility for community Medi-Cal reimbursable mental health services and the anticipated county matching funds needed for community Medi-Cal mental health services in that county to the department. The amount of the anticipated county matching funds shall be determined by the department in consultation with the county, and shall be adjusted annually. The amount transferred shall be based on historical cost, adjusted for changes in the number of Medi-Cal beneficiaries and other relevant factors. The anticipated county matching funds shall be used by the department to contract with another entity for mental health services, and shall not be expended for any other purpose but the provision of those services and related administrative costs. The county shall continue to deliver non-Medi-Cal reimbursable mental health services in accordance with this division, and subject to subdivision (i) of Section 5777.

(e) Whenever the department determines that a mental health plan has failed to comply with this part or any regulations adopted pursuant to this part that implement this part, the department may impose sanctions, including, but not limited to, fines, penalties, the withholding of payments, special requirements, probationary or corrective actions, or any other actions deemed necessary to prompt and ensure contract and performance compliance. If fines are imposed by the department, they

may be withheld from the state matching funds provided to a mental health plan for Medi-Cal mental health services.

(f) Notwithstanding any other provision of law, emergency regulations adopted pursuant to Section 14680 to implement the second phase of mental health managed care as provided in this part shall remain in effect until January 1, 2006.

(g) The department shall convene at least two public hearings to clarify new federal regulations recently enacted by the federal Centers for Medicare and Medicaid Services that affect the state's second phase of mental health managed care and shall report to the Legislature on the results of these hearings through the 2005–06 budget deliberations.

(h) The department may adopt emergency regulations necessary to implement Part 438 (commencing with Section 438.1) of Subpart A of Subchapter C of Chapter IV of Title 42 of the Code of Federal Regulations, in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. The adoption of emergency regulations to implement this part, that are filed with the Office of Administrative Law within one year of the date on which the act that amended this subdivision in 2003 took effect, shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, and safety, or general welfare, and shall remain in effect for no more than 180 days.

SEC. 10. Section 14007.9 of the Welfare and Institutions Code is amended to read:

14007.9. (a) The department shall adopt the option made available under Section 1902(a)(10)(A)(ii)(XIII) of the federal Social Security Act (42 U.S.C. Sec. 1396a(a)(10)(A)(ii)(XIII). In order to be eligible for benefits under this section, an individual shall be required to meet all of the following requirements:

(1) His or her net countable income is less than 250 percent of the federal poverty level for one person or, if the deeming of spousal income applies to the individual, his or her net countable income is less than 250 percent of the federal poverty level for two persons.

(2) He or she is disabled under Title II of the Social Security Act (Subch. 2 (commencing with Sec. 401), Ch. 7, Title 42 U.S.C.), Title XVI of the Social Security Act (Subch. 16 (commencing with Sec. 1381), Ch. 7, Title 42, U.S.C.), or Section 1902(v) of the Social Security Act (42 U.S.C. Sec. 1396a(v)). An individual shall be determined to be eligible under this section without regard to his or her ability to engage in, or actual engagement in, substantial gainful activity, as defined in Section 223(d)(4) of the Social Security Act (42 U.S.C. Sec. 423(d)(4)).

(3) Except as otherwise provided in this section, his or her net nonexempt resources, which shall be determined in accordance with the

methodology used under Title XVI of the federal Social Security Act (42 U.S.C. Sec. 1381 et seq.), are not in excess of the limits provided for under those provisions.

(b) (1) Countable income shall be determined under Section 1612 of the Social Security Act (42 U.S.C. Sec. 1382a), except that the individual's disability income, including all federal and state disability benefits and private disability insurance, shall be exempted. Resources excluded under Section 1613 of the Social Security Act (42 U.S.C. Sec. 1382b) shall be disregarded.

(2) Resources in the form of employer or individual retirement arrangements authorized under the Internal Revenue Code shall be exempted as authorized by Section 1902(r) of the Social Security Act (42 U.S.C. Sec. 1396a(r)).

(c) Medi-Cal benefits provided under this chapter pursuant to this section shall be available in the same amount, duration, and scope as those benefits are available for persons who are eligible for Medi-Cal benefits as categorically needy persons and as specified in Section 14007.5.

(d) Individuals eligible for Medi-Cal benefits under this section shall be subject to the payment of premiums determined under this subdivision. The department shall establish sliding-scale premiums that are based on countable income, with a minimum premium of twenty dollars ($20) per month and a maximum premium of two hundred fifty dollars ($250) per month, and shall, by regulations, annually adjust the premiums. Prior to adjustment of any premiums pursuant to this subdivision, the department shall submit a report of proposed premium adjustments to the appropriate committees of the Legislature as part of the annual budget act process.

(e) The department shall adopt regulations specifying the process for discontinuance of eligibility under this section for nonpayment of premiums for more than two months by a beneficiary.

(f) In order to implement the collection of premiums under this section, the department may develop and execute a contract with a public or private entity to collect premiums, or may amend any existing or future premium-collection contract that it has executed. Notwithstanding any other provision of law, any contract developed and executed or amended pursuant to this subdivision is exempt from the approval of the Director of General Services and from the Public Contract Code.

(g) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department shall implement, without taking any regulatory action, this section by means of an all-county letter or

similar instruction. Thereafter, the department shall adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(h) Notwithstanding any other provision of law, this section shall be implemented only if, and to the extent that, the department determines that federal financial participation is available pursuant to Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(i) Subject to subdivision (h), this section shall be implemented commencing April 1, 2000.

(j) This section shall become inoperative on September 1, 2008, and as of January 1, 2009, is repealed, unless a later enacted statute that is enacted on or before January 1, 2009, extends or deletes the dates on which it becomes inoperative and is repealed.

SEC. 10.3. Section 14018.7 of the Welfare and Institutions Code is amended to read:

14018.7. (a) Notwithstanding any other provision of law, neither a member of the governing body of the commission nor a member of any advisory panel to the governing body shall be deemed to be interested in a contract entered into by the commission within the meaning of Article 4 (commencing with Section 1090) of Chapter 1 of Division 4 of Title 1 of the Government Code if all of the following apply:

(1) The board of supervisors or the governing body appointed the individual to represent the interests of physicians, health care practitioners, hospitals, pharmacies, or other health care organizations.

(2) The contract authorizes the individual or the organization the individual represents to provide services under the local initiative.

(3) The contract contains substantially the same terms and conditions as contracts entered into with other individuals or organizations that the individual was appointed to represent.

(4) The individual does not influence or attempt to influence any advisory panel, the governing body, or any member of the governing body to enter into the contract.

(5) The individual discloses the interest to the governing body and the advisory panel, if applicable, and abstains from voting on the contract.

(6) The governing body and the advisory panel, if applicable, notes the disclosure and abstention in its official records and authorizes the contract in good faith by a vote of its membership sufficient for that purpose without counting the vote of the individual.

(b) (1) For purposes of this section, ‘‘commission’’ means a nonprofit corporation established in Kern County to operate the local health plan and other health care programs owned by, or operated in, Kern County.

(2) The commission shall be considered a public entity for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code.

(c) For purposes of this section, ''governing body'' means the board of directors of the nonprofit corporation established in Kern County, and ''board of supervisors'' means the Kern County Board of Supervisors.

(d) The commission may enter into agreements under Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code.

SEC. 10.5. Section 14043.46 is added to the Welfare and Institutions Code, to read:

14043.46. (a) Notwithstanding any other provision of law, on the effective date of the act adding this section, the department may implement a one-year moratorium on the certification and enrollment into the Medi-Cal program of new adult day health care centers on a statewide basis or within a geographic area.

(b) The moratorium shall not apply to the following:

(1) Programs of All-Inclusive Care for the Elderly (PACE) established pursuant to Chapter 8.75 (commencing with Section 14590).

(2) An organization that currently holds a designation as a federally qualified health center as defined in Section 1396d(*l*)(2) of Title 42 of the United States Code.

(3) An organization that currently holds a designation as a federally qualified rural health clinic as defined in Section 1396d(*l*)(1) of Title 42 of the United States Code.

(4) An applicant with the physical location of the center in an unserved area, which is defined as a county having no licensed and certified adult day health care center within its geographic boundary.

(c) The moratorium shall not prohibit the department from approving a change of ownership, relocation, or increase in capacity for an adult day health care center if the following conditions are met:

(1) For an application to change ownership, the adult day health care center meets all of the following conditions:

(A) Has been licensed and certified prior to the effective date of this section.

(B) Has a license in good standing.

(C) Has a record of substantial compliance with certification laws and regulations.

(D) Has met all requirements for the change application.

(2) For an application to relocate an existing facility, the relocation center must meet all of the conditions of paragraph (1) and both of the following conditions:

(A) Must be located in the same county as the existing licensed center.

(B) Must be licensed for the same capacity as the existing licensed center, unless the relocation center is located in an underserved area, which is defined as a county having 2 percent or fewer Medi-Cal beneficiaries over the age of 65 years using adult day health care services, based on 2002 calendar year Medi-Cal utilization data.

(3) For an application to increase the capacity of an existing facility, the center must meet all of the conditions of paragraph (1) and must be located in an underserved area, which is defined as a county having 2 percent or fewer Medi-Cal beneficiaries over the age of 65 years using adult day health care services, based on 2002 calendar year Medi-Cal utilization data.

(d) Following the first 180 days of the moratorium period, the department may make exceptions to the moratorium for new adult day health care centers that are located in underserved areas if the center's application was on file with the department on or before the effective date of the act adding this section. In order to apply for this exemption, an applicant or licensee must meet all of the following criteria:

(1) The applicant has control of a facility, either by ownership or lease agreement, that will house the adult day health care center, has provided to the department all necessary documents and fees, and has completed and submitted all required fingerprinting forms to the department.

(2) The physical location of the applicant's or licensee's adult day health care center is in an underserved area, which is defined as a county having 2 percent or fewer Medi-Cal beneficiaries over the age of 65 years using adult day health care services, based on 2002 calendar year Medi-Cal utilization data.

(e) During the period of the moratorium, a licensee or applicant that meets the criteria for an exemption as defined in subdivision (d) may submit a written request for an exemption to the director.

(f) If the director determines that a new adult day health care licensee or applicant meets the exemption criteria, the director may certify the licensee or applicant, once licensed, for participation in the Medi-Cal program.

(g) The director may extend this moratorium, if necessary, to coincide with the implementation date of the adult day health care waiver.

(h) The authority granted in this section shall not be interpreted as a limitation on the authority granted to the department in any other section.

SEC. 10.7. Section 14044 of the Welfare and Institutions Code is amended to read:

14044. (a) The department may limit, for 18 months or less, the American Medical Association's Current Procedural Terminology Fourth Edition (CPT-4) codes, the National Drug Codes (NDC), the

Healthcare Common Procedure Coding System (HCPCS) codes, or codes established under Title II of the Health Insurance Portability & Accountability Act of 1996 (42 U.S.C. Sec. 1320d et seq.) for which any provider may bill, or for which reimbursement to any person or entity may be made by, the Medi-Cal program or other health care programs administered by the department if either of the following conditions exist:

(1) The department determines, by audit or other investigation, that excessive services or billings, or abuse, has occurred, which may include the department's discovery or determination that a claim was submitted for reimbursement under the Medi-Cal program for a nerve conduction test, electromyography, or procedures, tests, examinations, or other medical services that the department has specified requires a certain residency or board certification, but the records did not contain, or the person or entity submitting the claim for reimbursement did not have, the certificate or diploma required by Section 14170.11.

(2) The Medical Board of California or other licensing authority or a court of competent jurisdiction limits a licensee's practice of medicine or the rendering of health care, and the limitation precludes the licensee from performing services that could otherwise be reimbursed by the Medi-Cal program or other health care programs administered by the department.

(b) The department may impose a limitation pursuant to subdivision (a) for one or more codes or any combination of codes after giving the provider notice of the proposed limitation and, if applicable, the opportunity to appeal pursuant to subdivision (c).

(c) (1) A provider who receives notice of a proposed limitation based on paragraph (1) of subdivision (a) shall have 45 days from the date of notice to appeal the limitation by providing to the department reliable evidence that excessive services or billings, or abuse, did not occur.

(2) The department shall review the evidence and issue a decision within 45 days of receipt of the evidence.

(d) If a limitation is imposed pursuant to paragraph (1) of subdivision (a), it shall take effect on the 46th day after notice of the proposed limitation was given or, if the limitation is timely appealed, 15 days after the department gives the provider notice of its decision to impose the limitation. If a limitation is imposed pursuant to paragraph (2) of subdivision (a), it shall take effect 15 days after notice of the proposed limitation was given.

(e) If the department's limitation could interfere with the provider's or other prescriber's ability to provide health care services to a beneficiary, the burden to transfer a patient's care to another qualified person shall remain the responsibility of the licensee.

(f) For purposes of this section, the following definitions apply:

(1) ''Abuse'' has the same meaning as defined in Section 14043.1.

(2) ''Administered by the department'' means administered by the department or its agents or contractors.

(3) ''Excessive services or billings'' means an amount that is substantially in excess of what the department reasonably expects from the provider, based on data regarding the provider or other providers in the health care community who provide substantially similar services to a substantially similar patient population, that is available to the department from any source, including the department.

(4) ''Licensee'' means a person licensed under Division 2 (commencing with Section 500) of the Business and Professions Code.

(5) ''Other prescriber'' means that person who is not the primary or attending physician for a patient who is a beneficiary of the Medi-Cal program or other health care program administered by the department, and that person causes the department, or its agents or contractors, to provide reimbursement for a drug, device, medical service, or supply to the beneficiary.

(6) ''Provider'' has the same meaning as defined in Section 14043.1.

SEC. 11. Section 14085.7 of the Welfare and Institutions Code is amended to read:

14085.7. (a) The Medi-Cal Medical Education Supplemental Payment Fund is hereby created in the State Treasury. Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to, and under the administrative control of, the department for the purposes specified in this section. Except as otherwise limited by this section, the fund shall consist of all of the following:

(1) All public moneys transferred by public agencies to the department for deposit into the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal medicaid laws.

(2) All private moneys donated by private individuals or entities to the department for deposit in the fund as permitted under applicable federal medicaid laws.

(3) Any amounts appropriated to the fund by the Legislature.

(4) Any interest that accrues on amounts in the fund.

(b) Any public agency transferring moneys to the fund may, for that purpose, utilize any revenues, grants, or allocations received from the state for health care programs or purposes, unless otherwise prohibited by law. A public agency may also utilize its general funds or any other public moneys or revenues for purposes of transfers to the fund, unless otherwise prohibited by law.

(c) The department shall have the discretion to accept or not accept moneys offered to the department for deposit in the fund. If the department accepts moneys pursuant to this section, the department shall obtain federal matching funds to the full extent permitted by law. The department shall accept only those funds that are certified by the transferring or donating entity as qualifying for federal financial participation under the terms of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) or Section 433.51 of Title 42 of the Code of Federal Regulations, as applicable, and may return any funds transferred or donated in error.

(d) Moneys in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures for purposes of payments under subdivision (e). Distributions from the fund shall be supplemental to any other amounts that hospitals receive under the contracting program.

(e) For purposes of recognizing medical education costs incurred for services rendered to Medi-Cal beneficiaries, payments from this fund shall be negotiated between the California Medical Assistance Commission and hospitals contracting under this article that meet the definition of university teaching hospitals or major (nonuniversity) teaching hospitals as set forth on page 51 and as listed on page 57 of the department's report dated May 1991, entitled ''Hospital Peer Grouping.'' Payments from the fund shall be used solely for the purposes identified in the contract between the hospital and the state.

(f) The state shall be held harmless from any federal disallowance resulting from this section. A hospital receiving supplemental reimbursement pursuant to this section shall be liable for any reduced federal financial participation resulting from the implementation of this section with respect to that hospital. The state may recoup any federal disallowance from the hospital.

SEC. 12. Section 14085.8 of the Welfare and Institutions Code is amended to read:

14085.8. (a) The Large Teaching Emphasis Hospital and Children's Hospital Medi-Cal Medical Education Supplemental Payment Fund is hereby created in the State Treasury.

(b) Notwithstanding Section 13340 of the Government Code, the fund shall be continuously appropriated to, and under the administrative control of, the department for the purposes specified in this section.

(c) Except as otherwise limited by this section, the fund shall consist of all of the following:

(1) All public moneys transferred by public agencies to the department for deposit into the fund, as permitted under Section 433.51 of Title 42 of the Code of Federal Regulations or any other applicable federal medicaid laws.

(2) All private moneys donated by private individuals or entities to the department for deposit in the fund as permitted under applicable federal medicaid laws.

(3) Any amounts appropriated to the fund by the Legislature.

(4) Any interest that accrues on amounts in the fund.

(d) Any public agency transferring moneys to the fund may, for that purpose, utilize any revenues, grants, or allocations received from the state for health care programs or purposes, unless otherwise prohibited by law. A public agency may also utilize its general funds or any other public moneys or revenues for purposes of transfers to the fund, unless otherwise prohibited by law.

(e) The department may accept or not accept moneys offered to the department for deposit in the fund. If the department accepts moneys pursuant to this section, the department shall obtain federal matching funds to the full extent permitted by law. The department shall accept only those funds that are certified by the transferring or donating entity as qualifying for federal financial participation under the terms of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 (P.L. 102-234) or Section 433.51 of Title 42 of the Code of Federal Regulations, as applicable, and may return any funds transferred or donated in error.

(f) Moneys in the fund shall be used as the source for the nonfederal share of payments to hospitals under this section. Moneys shall be allocated from the fund by the department and matched by federal funds in accordance with customary Medi-Cal accounting procedures for purposes of payments under subdivision (g). Distributions from the fund shall be supplemental to any other amounts that hospitals receive under the contracting program.

(g) (1) For purposes of recognizing medical education costs incurred for services rendered to Medi-Cal beneficiaries, contracts for payments from the fund may, at the discretion of the California Medical Assistance Commission, be negotiated between the commission and hospitals contracting under this article that are defined as either of the following:

(A) A large teaching emphasis hospital, as set forth on page 51 and listed on page 57 of the department's report dated May 1991, entitled ''Hospital Peer Grouping,'' and meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.

(B) A children's hospital pursuant to Section 10727 and meets the definition of eligible hospital as defined in paragraph (3) of subdivision (a) of Section 14105.98.

(2) Payments from the fund shall be used solely for the purposes identified in the contract between the hospital and the state.

(h) The state shall be held harmless from any federal disallowance resulting from this section. A hospital receiving supplemental reimbursement pursuant to this section shall be liable for any reduced federal financial participation resulting from the implementation of this section with respect to that hospital. The state may recoup any federal disallowance from the hospital.

SEC. 12.1. Section 14087.31 of the Welfare and Institutions Code is amended to read:

14087.31. (a) It is necessary that a special commission be established in the Counties of Tulare and San Joaquin in order to meet the problems of delivery of publicly assisted medical care in the county and to demonstrate ways of promoting quality care and cost efficiency. Because there is no general law under which such a commission could be formed, the adoption of a special act and the formation of a special commission is required.

(b) (1) The Board of Supervisors of the County of Tulare and the County of San Joaquin may, for each respective county, by ordinance, establish a commission to negotiate and enter into contracts authorized by Section 14087.3, and to arrange for the provision of health care services provided pursuant to this chapter. If the board of supervisors elects to enact this ordinance, all rights, powers, duties, privileges, and immunities vested in a county contracting with the department under this article shall be vested in the county commission.

(2) Health plans operated by the commission may also include, but are not limited to, individuals covered under Title XVIII of the Social Security Act (Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code), individuals and groups entitled to coverage under other publicly supported programs, individuals and groups employed by public agencies or private businesses, and uninsured or indigent persons.

(c) The enabling ordinance shall specify the membership of the county commission, the qualifications for individual members, the manner of appointment, selection, or removal of commissioners, and how long they shall serve, and any other matters as the board of supervisors deems necessary or convenient for the conduct of the county commission's activities. Members of the commission shall be appointed by the county board of supervisors to represent the interests of the public, county, beneficiaries, physicians, hospitals, other health care providers,

or other health care organizations. The commission so established shall be considered an entity separate from the county and shall file a statement required by Section 53051 of the Government Code. The commission shall have the power to acquire, possess, and dispose of real or personal property, as may be necessary for the performance of its functions, to employ personnel and contract for services required to meet its obligations, to sue or be sued, and to enter into agreements under Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code. Any obligations of a commission, statutory, contractual or otherwise, shall be obligations solely of the commission and shall not be the obligations of the county or of the state.

(d) Upon creation, the commission may borrow from the county, and the county may lend the commission, funds or issue revenue anticipation notes to obtain those funds necessary to commence operations. Prior to commencement of operations, the commission shall be licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(e) In the event a commission may no longer function for the purposes for which it is established, at the time as the commission's then existing obligations have been satisfied or the commission's assets have been exhausted, the board of supervisors may, by ordinance, terminate the commission.

(f) Prior to the termination of the commission, the board of supervisors shall notify the department of its intent to terminate the commission. The department shall conduct an audit of the commission's records within 30 days of the notification to determine the liabilities and assets of the commission. The department shall report its findings to the board within 10 days of completion of the audit. The board shall prepare a plan to liquidate or otherwise dispose of the assets of the commission and to pay the liabilities of the commission to the extent of the commission's assets, and present the plan to the department within 30 days upon receipt of these findings.

(g) Any assets of the commission shall be disposed of pursuant to provisions contained in the contract entered into between the state and the commission pursuant to Section 14087.

(h) (1) It is the intent of the Legislature that if a commission is formed pursuant to this section, the county shall, with respect to its medical facilities and programs, occupy no greater or lesser status than any other health care provider with similar cost structure and patient population including, but not limited to, considerations of indigent care burden, capital requirements, graduate medical education, and

disproportionate share status, in negotiating with the commission for contracts to provide health care services.

(2) Contracts between the department and the commission shall be on a nonbid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(3) Nothing in this subdivision shall be construed to interfere with or limit the commission from giving preference in negotiating to disproportionate share hospitals or other providers of health care to medically indigent or uninsured persons.

(i) Upon termination of the commission by the board, the county shall manage any remaining assets of the commission until superseded by a department approved plan. Any liabilities of the commission shall not become obligations of the county upon either the termination of the commission or the liquidation or disposition of the commission's remaining assets.

(j) (1) The commission shall be considered a public entity for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code.

(2) The commission, its members, and employees, are protected by the immunities applicable to public entities and public employees governed by Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, except as provided by other statutes or regulations that apply expressly to the commission.

(k) Notwithstanding any other provision of law, a member of the commission shall not be deemed to be interested in a contract entered into by the commission within the meaning of Article 4 (commencing with Section 1090) of Chapter 1 of Division 4 of Title 1 of the Government Code if all of the following apply:

(1) The member was appointed to represent the interest of physicians, health care practitioners, hospitals, pharmacies, or other health care organizations.

(2) The contract authorizes the member or the organization the member represents to provide services to Medi-Cal beneficiaries under the commission's programs.

(3) The contract contains substantially the same terms and conditions as contracts entered into with other individuals or organizations that the member was appointed to represent.

(4) The member does not influence or attempt to influence the commission or another member of the commission to enter into the contract in which the member is interested.

(5) The member discloses the interest to the commission and abstains from voting on the contract.

(6) The commission notes the member's disclosure and abstention in its official records and authorized the contract in good faith by a vote of its membership sufficient for the purpose without counting the vote of the interested member.

(*l*) All claims for money or damages against the commission shall be governed by Part 3 (commencing with Section 900) and Part 4 (commencing with Section 940) of Division 3.6 of Title 1 of the Government Code, except as provided by other statutes or regulations that expressly apply to the commission.

(m) Notwithstanding any other provision of law, except as otherwise provided in this section, a county shall not be liable for any act or omission of the commission.

(n) For the purposes of this section, ''commission'' means an entity separate from the county that meets the requirements of state and federal law and the quality, cost, and access criteria established by the department.

(o) The transfer of responsibility for health care services shall not relieve the county of its responsibility for indigent care pursuant to Section 17000.

(p) Notwithstanding any other provision of law, the commission may meet in closed session to consider and take action on matters pertaining to contracts and contract negotiations by commission staff with providers of health care services concerning all matters related to rates of payment.

(q) Notwithstanding Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code and Article 2 (commencing with Section 54340) of Chapter 6 of Division 2 of Title 5 of the Government Code, or any other provision of law, any ''peer review body,'' as defined in paragraph (1) of subdivision (a) of Section 805 of the Business and Professions Code, formed pursuant to the powers granted to the commission authorized by this section, may, at its discretion and without notice to the public, meet in closed session, so long as the purpose of the meeting is the peer review body's discharge of its responsibility to evaluate and improve the quality of care rendered by health facilities of health practitioners, pursuant to the powers granted the commission. The peer review body and its members shall receive to the fullest extent all immunities, privileges, and protections available to these peer review bodies, their individual members, and persons or entities assisting in the peer review process, including, but not limited to, those afforded by Section 1370 of the Health and Safety Code.

(r) Notwithstanding any other provision of law, both the county and the commission shall be eligible to receive funding under subdivision (p)

of Section 14163, and the commission shall be considered for all purposes to satisfy the requirements of subdivision (p) of Section 14163.

(s) The commission shall be deemed to be a public agency that is a unit of local government for purposes of all grant programs and other funding and loan guarantee programs.

(t) Notwithstanding any other provision of law, those records of the commission and of the county that reveal the rates of payment for health care services or the commission's deliberative processes, discussions, communications, or any other portion of the negotiations with providers of health care services for rates of payment, shall not be disclosed pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), or any similar local law requiring disclosure of public records. However, three years after a contract or amendment to a contract is fully executed, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(u) Notwithstanding the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), Article 3 (commencing with Section 11200) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code, Chapter 9 (commencing with Section 54960) of Part 1 of Division 2 of Title 5 of the Government Code, or any other provision of state or local law requiring disclosure of public records, those records of the commission and the county that reveal the proceedings of a peer review body, as defined in paragraph (1) of subdivision (a) of Section 805 of the Business and Professions Code, formed pursuant to the powers granted to the commission authorized by this section, shall not be required to be disclosed. The records and proceedings of the peer review body and its members shall receive to the fullest extent, all immunities, privileges, and protections available to these records and proceedings, including, but not limited to, those afforded by Section 1157 of the Evidence Code.

(v) (1) Provisions of the Evidence Code, the Government Code, including the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), the Civil Code, the Business and Professions Code, and other applicable law pertaining to the confidentiality of peer review activities of peer review bodies shall apply to the peer review activities of the commission. Peer review proceedings shall constitute an official proceeding authorized by law within the meaning of Section 47 of the Civil Code, and those privileges set forth in that section with respect to official proceedings shall apply to peer review proceedings of the commission. If the commission is required by law or contractual obligation to submit to the state or federal government peer review

information or information relevant to the credentialing of a participating provider, that submission shall not constitute a waiver of confidentiality. All laws pertaining to the confidentiality of peer review activities shall be construed together as extending, to the extent permitted by law, the maximum degree of protection of confidentiality.

(2) Notwithstanding any other provision of law, Section 1461 of the Health and Safety Code shall apply to hearings on the reports of hospital medical audit or quality assurance committees as they relate to network providers or applicants.

(w) Except as expressly provided by other provisions of this section, all exemptions and exclusions from disclosure as public records pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), including, but not limited to, those pertaining to trade secrets and information withheld in the public interest, shall be fully applicable for all state agencies and local agencies with respect to all writings that the commission is required to prepare, produce, or submit pursuant to this section.

(x) (1) The commission may use a computerized management information system in connection with the administration of its health delivery system, including the administration of the state-mandated two-plan Medi-Cal managed care model.

(2) Information maintained in the management information system that pertains to persons who are Medi-Cal applicants or recipients shall be confidential pursuant to Section 14100.2, and shall not be open to examination other than for purposes directly connected with the administration of the Medi-Cal program, including, but not limited to, those set forth in subdivision (c) of Section 14100.2. This safeguarded information includes, but is not limited to, the names and addresses of recipients, the medical services provided, the social and economic conditions or circumstances of the recipients, an evaluation by the commission of personal information, and medical data, including the diagnosis and past history of disease or disability.

(3) Information maintained in the management information system that pertains to peer review-related activities shall be confidential and subject to the full protections of the law with respect to the confidentiality of activities related to peer review generally.

(y) (1) The records of the commission, whether paper records, records maintained in the management information system, or records in any other form, that relate to rates of payment, including records relating to rates of payment determination, allocation or distribution methodologies, formulas or calculations, and records of the health authority that relate to contract negotiations with providers of health care

for alternative rates, shall not be subject to disclosure pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(2) The transmission of the records of the commission, or the information contained therein in an alternative form, to the board of supervisors shall not constitute a waiver of exemption from disclosure, and the records and information, once transmitted to the county board of supervisors, shall be subject to this same exemption. The information, if compelled pursuant to an order of a court of competent jurisdiction or administrative body in a manner permitted by law, shall be limited to in camera review, and shall not be shared with the parties to the proceeding.

(3) The submission, to the Department of Managed Health Care, of information described in this section for the purpose of obtaining licensure under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, or to the State Department of Health Services, shall not constitute a waiver of exemption from disclosure.

(z) (1) (A) Notwithstanding the Ralph M. Brown Act (Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code), the commission may meet in closed session for the purpose of discussion of, or taking action on matters involving, commission trade secrets.

(B) The requirement that the commission make a public report of actions taken in closed session and the vote or abstention of every member present may be limited to a brief general description of the action taken and the vote so as to prevent the disclosure of a trade secret.

(C) For purposes of this subdivision, ‘‘commission trade secret’’ means a trade secret, as defined in subdivision (d) of Section 3426.1 of the Civil Code, that also meets both of the following criteria:

(i) The secrecy of the information is necessary for the commission to initiate a new service, program, marketing strategy, business plan, or technology, or to add a benefit or product.

(ii) Premature disclosure of the trade secret would create a substantial probability of depriving the commission of a substantial economic benefit or opportunity.

(2) Those records of the commission that reveal the commission’s trade secrets are exempt from disclosure pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records. This exemption shall apply for a period of two years after the service, program, marketing strategy, business plan, technology, benefit, or product that is the subject of the trade secret is formally adopted by the governing body of the

commission, provided that the service, program, marketing strategy, business plan, technology, benefit, or product continues to be a trade secret. The commission may delete the portion or portions containing trade secrets from any documents that were finally approved in the closed session held pursuant to paragraph (1) that are provided to persons who have made the timely or standing request.

(3) Nothing in this section shall be construed as preventing the commission from meeting in closed session as otherwise provided by law.

SEC. 12.2. Section 14087.35 of the Welfare and Institutions Code is amended to read:

14087.35. (a) Because of the unique circumstances that exist in the County of Alameda, it is necessary that the Board of Supervisors of the County of Alameda be given authority to create a health authority separate and apart from the County of Alameda as a means of establishing the local initiative component of the state-mandated two-plan managed care model for the delivery of medical care and services to the Medi-Cal populations. It is further necessary to enable the board of supervisors to expand publicly assisted medical and health care delivery by the newly created health authority to other populations should the board of supervisors elect to do so. Thus, the adoption of a special act is required.

(b) The Board of Supervisors of the County of Alameda may, by ordinance, establish a health authority separate and apart from the County of Alameda, whose governing board shall reflect the diversity of local stakeholders such as provider groups, beneficiary groups, and officials of government, and that is appointed by the board of supervisors. Notwithstanding any other provision of this chapter, the governing board may include, but need not be limited to, the following: a member of the board of supervisors, individuals that represent and further the interests of the perspectives of Medi-Cal beneficiaries, and individuals that represent and further the interests of the perspectives of Medi-Cal provider physicians and other health practitioners, hospitals, and nonprofit community health centers. Other perspectives may be represented at the discretion of the board of supervisors. The enabling ordinance shall more specifically set forth the membership of the health authority governing board, the qualifications for individual members, the manner of appointment, selection, or removal of governing board members, their terms of office, and all other matters that the board of supervisors deems necessary or convenient for the conduct of the health authority’s activities.

(c) The governing board of the health authority and the appropriate state departments, to the extent permitted by federal law, may negotiate

and enter into contracts to provide or arrange for health care services for any or all persons who are eligible to receive benefits under the Medi-Cal program and for other targeted populations. The contracts may be on an exclusive or nonexclusive basis, and shall include payment provisions on any basis negotiated between the state and health authority. Prior to the commencement of operations, the health authority shall be licensed as a health care service plan pursuant to the Knox-Keene Health Care Services Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(d) The board of supervisors may transfer responsibility for administration of county-provided health care services to the health authority for the purpose of service of populations including uninsured and indigent persons subject to the provisions of any ordinances or resolutions passed by the board of supervisors. The transfer of administrative responsibility for those health care services shall not relieve the county of its responsibility for indigent care pursuant to Section 17000. In addition, the services and programs of the health authority may include, but are not limited to, individuals covered under Title XVIII of the Social Security Act, contained in Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, and individuals and groups employed by public agencies and private businesses.

(e) As a legal entity separate and apart from the County of Alameda, the health authority shall file the statement required by Section 53051 of the Government Code. The health authority shall have the power to acquire, possess, and dispose of real or personal property as may be necessary for the performance of its functions, to sue or be sued, to employ personnel and contract for services required to meet its obligations, and to enter into agreements under Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code.

(f) (1) The health authority shall be deemed to be a legal entity separate and apart from the County of Alameda, and shall not be considered to be an agency, division, department, or instrumentality of the County of Alameda.

(2) The health authority shall not be governed by, nor be subject to, the Charter of the County of Alameda and shall not be subject to county policies or operational rules, including, but not limited to, those relating to personnel and procurement.

(g) The health authority shall be considered a public entity, and employees of the health authority shall be considered public employees, for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, relating to claims and actions against public entities and public employees. Members of the governing board of the

health authority shall not be vicariously liable for injuries caused by the act or omission of the health authority or advisory body to the extent that protection applies to members of governing boards of local public entities generally under Section 820.9 of the Government Code.

(h) Upon the enactment of the ordinance, all rights, powers, duties, privileges, and immunities vested in the County of Alameda with respect to the subject matter of this section shall be vested in the health authority. Any obligation of the health authority, statutory, contractual, or otherwise, shall be the obligation solely of the health authority and shall not be the obligation of the County of Alameda or the state.

(i) The health authority shall not be a ''person'' subject to suit under the Cartwright Act, Chapter 2 (commencing with Section 16700) of Part 2 of Division 7 of the Business and Professions Code.

(j) The health authority created pursuant to this section may borrow from the county and the county may lend the health authority funds, or issue revenue anticipation notes to obtain those funds necessary to commence operations.

(k) The health authority or the county, or both, may engage in marketing, advertising, and promotion of the medical and health care services made available to the target populations by the health authority.

(*l*) Provisions for the termination of the health authority's activities with respect to the delivery of services to Medi-Cal populations shall be contained in the appropriate contracts executed by and between the health authority and the appropriate state departments.

(m) If the board of supervisors expands publicly assisted medical and health care delivery by the health authority to other populations, and the board of supervisors subsequently determines that the health authority may no longer function for the purpose of the expanded delivery, at the time as the health authority's existing obligations with respect thereto have been satisfied, the board of supervisors may, by ordinance, terminate the expanded delivery activities of the health authority.

(n) All assets of the health authority that are related to Medi-Cal services shall be disposed of pursuant to the Medi-Cal related contract entered into between the state and the health authority.

(o) All liabilities or obligations of the health authority with respect to its activities pursuant to the state-mandated two-plan managed care model for the delivery of medical care and services to the Medi-Cal population shall be the liabilities or obligations of the health authority, and shall not become the liabilities or obligations of the county upon the termination of the health authority or at any other time. Any liabilities or obligations of the health authority with respect to the liquidation or disposition of the health authority's assets upon termination of the health authority shall not become the liabilities or obligations of the county,

except that the county shall manage any remaining Medi-Cal related assets of the health authority until superseded by a plan approved by the department.

(p) The Legislature finds and declares that Section 14105 provides that the Director of Health Services prescribe the policies for the administration of Medi-Cal managed care contracts. The state-mandated two-plan managed care model distributed by the director sets forth that policy, expressly providing that local stakeholders, including government officials, providers, and community-based organizations, are afforded maximum flexibility and control in designing a delivery system that reflects the needs and priorities of the community that it serves. The mandated model requires that the governing board of the local initiative reflect an effort to include representation of the perspectives of provider and beneficiary groups. To effectuate this policy, all of the following shall apply:

(1) Notwithstanding any provision of law to the contrary, a member of the governing board of the health authority shall be deemed not to be interested in a contract entered into by the health authority within the meaning of Article 4 (commencing with Section 1090) of Chapter 1 of Division 4 of Title 1 of the Government Code if all the following apply:

(A) The member was appointed to represent the interests of physicians, health care practitioners, hospitals, pharmacies, or other health care organizations.

(B) The contract authorizes the member or the organization the member represents to provide services to beneficiaries or administrative services under the health authority's programs.

(C) The contract contains substantially the same terms and conditions as contracts entered into with other individuals or organizations that the member was appointed to represent.

(D) The member does not influence or attempt to influence the health authority or another member of the health authority to enter into the contract in which the member is interested.

(E) The member discloses the interest to the health authority and abstains from voting on the contract.

(F) The health authority notes the member's disclosure and abstention in its official records and authorizes the contract in good faith by a vote of its membership sufficient for the purpose without counting the vote of the interested member.

(2) Notwithstanding Article 4.7 (commencing with Section 1125) of Chapter 1 of Division 4 of Title 1 of the Government Code related to incompatible activities, no member of the governing board, no officer, and no member of the alliance staff shall be considered to be engaged in activities inconsistent and incompatible with his or her duties as a

governing board member, officer, or staff person solely as a result of employment or affiliation with the county, private hospital, clinic, pharmacy, other provider group, employee organization, or citizen's group.

(q) (1) The health authority may use a computerized management information system in connection with the administration of its health delivery system, including the administration of the state-mandated two-plan Medi-Cal managed care model.

(2) Information maintained in the management information system that pertains to persons who are Medi-Cal applicants or recipients shall be confidential pursuant to Section 14100.2, and shall not be open to examination other than for purposes directly connected with the administration of the Medi-Cal program, including, but not limited to, those set forth in subdivision (c) of Section 14100.2. This safeguarded information includes, but is not limited to, names and addresses, medical services provided, social and economic conditions or circumstances, health authority evaluation of personal information, and medical data, including diagnosis and past history of disease or disability.

(3) Information maintained in the management information system that pertains to peer review-related activities shall be confidential and subject to the full protections of the law with respect to the confidentiality of activities related to peer review generally.

(r) The records of the health authority, whether paper records, records maintained in the management information system, or records in any other form, that relate to rates of payment, including records relating to rates of payment determination, allocation or distribution methodologies, formulas or calculations, and records of the health authority that relate to contract negotiations with providers of health care for alternative rates, shall not be subject to disclosure pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). The transmission of the records, or the information contained therein in an alternative form, to the board of supervisors shall not constitute a waiver of exemption from disclosure, and the records and information once transmitted to the board of supervisors shall be subject to this same exemption.

(s) (1) (A) Notwithstanding the Ralph M. Brown Act (Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code), the governing board of the health authority may meet in closed session for the purpose of discussion of, or taking action on matters involving, health authority trade secrets.

(B) The requirement that the authority make a public report of actions taken in closed session and the vote or abstention of every member

present may be limited to a brief general description of the action taken and the vote so as to prevent the disclosure of a trade secret.

(C) For purposes of this subdivision, ‘‘health authority trade secret’’ means a trade secret, as defined in subdivision (d) of Section 3426.1 of the Civil Code, that also meets both of the following criteria:

(i) The secrecy of the information is necessary for the health authority to initiate a new service, program, marketing strategy, business plan, or technology, or to add a benefit or product.

(ii) Premature disclosure of the trade secret would create a substantial probability of depriving the health authority of a substantial economic benefit or opportunity.

(2) Those records of the health authority that reveal the health authority’s trade secrets are exempt from disclosure pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records. This exemption shall apply for a period of two years after the service, program, marketing strategy, business plan, technology, benefit, or product that is the subject of the trade secret is formally adopted by the governing body of the health authority, provided that the service, program, marketing strategy, business plan, technology, benefit, or product continues to be a trade secret. The governing board may delete the portion or portions containing trade secrets from any documents that were finally approved in the closed session held pursuant to paragraph (1) that are provided to persons who have made the timely or standing request.

(3) Nothing in this section shall be construed as preventing the governing board from meeting in closed session as otherwise provided by law.

(t) Open sessions of the health authority shall constitute official proceedings authorized by law within the meaning of Section 47 of the Civil Code, and those privileges set forth in that section with respect to official proceedings shall apply to open sessions of the health authority.

(u) The health authority shall be considered a public agency for purposes of eligibility with respect to grants and other funding and loan guarantee programs. Contributions to the health authority shall be tax deductible to the extent permitted by state and federal law.

(v) Contracts by and between the health authority and the state, and contracts by and between the health authority and providers of health care, goods, or services may be let on a nonbid basis, and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(w) (1) Provisions of the Evidence Code, the Government Code, including the California Public Records Act (Chapter 3.5 (commencing

with Section 6250) of Division 7 of Title 1 of the Government Code), the Civil Code, the Business and Professions Code, and other applicable law pertaining to the confidentiality of peer review activities of peer review bodies shall apply to the peer review activities of the health authority. Peer review proceedings shall constitute an official proceeding authorized by law within the meaning of Section 47 of the Civil Code, and those privileges set forth in that section with respect to official proceedings shall apply to peer review proceedings of the health authority. If the health authority is required by law or contractual obligation to submit to the state or federal government peer review information or information relevant to the credentialing of a participating provider, that submission shall not constitute a waiver of confidentiality. The laws pertaining to the confidentiality of peer review activities shall be together construed as extending, to the extent permitted by law, the maximum degree of protection of confidentiality.

(2) Notwithstanding any other provision of law, Section 1461 of the Health and Safety Code shall apply to hearings on the reports of hospital medical audit or quality assurance committees as they relate to network providers or applicants.

(x) The health authority shall carry general liability insurance to the extent sufficient to cover its activities.

(y) The establishment of a health authority under Article 2.8 (commencing with Section 14087.5) shall be valid as if established pursuant to this section and this section shall apply to that health authority.

SEC. 12.3. Section 14087.36 of the Welfare and Institutions Code is amended to read:

14087.36. (a) The following definitions shall apply for purposes of this section:

(1) ''County'' means the City and County of San Francisco.

(2) ''Board'' means the Board of Supervisors of the City and County of San Francisco.

(3) ''Department'' means the State Department of Health Services.

(4) ''Governing body'' means the governing body of the health authority.

(5) ''Health authority'' means the separate public agency established by the board of supervisors to operate a health care system in the county and to engage in the other activities authorized by this section.

(b) The Legislature finds and declares that it is necessary that a health authority be established in the county to arrange for the provision of health care services in order to meet the problems of the delivery of publicly assisted medical care in the county, to enter into a contract with the department under Article 2.97 (commencing with Section 14093),

or to contract with a health care service plan on terms and conditions acceptable to the department, and to demonstrate ways of promoting quality care and cost efficiency.

(c) The county may, by resolution or ordinance, establish a health authority to act as and be the local initiative component of the Medi-Cal state plan pursuant to regulations adopted by the department. If the board elects to establish a health authority, all rights, powers, duties, privileges, and immunities vested in a county under Article 2.8 (commencing with Section 14087.5) and Article 2.97 (commencing with Section 14093) shall be vested in the health authority. The health authority shall have all power necessary and appropriate to operate programs involving health care services, including, but not limited to, the power to acquire, possess, and dispose of real or personal property, to employ personnel and contract for services required to meet its obligations, to sue or be sued, to take all actions and engage in all public and private business activities, subject to any applicable licensure, as permitted a health care service plan pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, and to enter into agreements under Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code.

(d) (1) (A) The health authority shall be considered a public entity for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, separate and distinct from the county, and shall file the statement required by Section 53051 of the Government Code. The health authority shall have primary responsibility to provide the defense and indemnification required under Division 3.6 (commencing with Section 810) of Title 1 of the Government Code for employees of the health authority who are employees of the county. The health authority shall provide insurance under terms and conditions required by the county in order to satisfy its obligations under this section.

(B) For purposes of this paragraph, ‘‘employee’’ shall have the same meaning as set forth in Section 810.2 of the Government Code.

(2) The health authority shall not be considered to be an agency, division, department, or instrumentality of the county and shall not be subject to the personnel, procurement, or other operational rules of the county.

(3) Notwithstanding any other provision of law, any obligations of the health authority, statutory, contractual, or otherwise, shall be the obligations solely of the health authority and shall not be the obligations of the county, unless expressly provided for in a contract between the authority and the county, nor of the state.

(4) Except as agreed to by contract with the county, no liability of the health authority shall become an obligation of the county upon either

termination of the health authority or the liquidation or disposition of the health authority's remaining assets.

(e) (1) To the full extent permitted by federal law, the department and the health authority may enter into contracts to provide or arrange for health care services for any or all persons who are eligible to receive benefits under the Medi-Cal program. The contracts may be on an exclusive or nonexclusive basis, and shall include payment provisions on any basis negotiated between the department and the health authority. The health authority may also enter into contracts for the provision of health care services to individuals including, but not limited to, those covered under Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, individuals employed by public agencies and private businesses, and uninsured or indigent individuals.

(2) Notwithstanding paragraph (1), or subdivision (f), the health authority may not operate health plans or programs for individuals covered under Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, or for private businesses, until the health authority is in full compliance with all of the requirements of the Knox-Keene Health Care Service Plan Act of 1975 under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, including tangible net equity requirements applicable to a licensed health care service plan. This limitation shall not preclude the health authority from enrolling persons pursuant to the county's obligations under Section 17000, or from enrolling county employees.

(f) The board of supervisors may transfer responsibility for administration of county-provided health care services to the health authority for the purpose of service of populations including uninsured and indigent persons, subject to the provisions of any ordinances or resolutions passed by the county board of supervisors. The transfer of administrative responsibility for those health care services shall not relieve the county of its responsibility for indigent care pursuant to Section 17000. The health authority may also enter into contracts for the provision of health care services to individuals including, but not limited to, those covered under Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, and individuals employed by public agencies and private businesses.

(g) Upon creation, the health authority may borrow from the county and the county may lend the authority funds, or issue revenue anticipation notes to obtain those funds necessary to commence operations or perform the activities of the health authority. Notwithstanding any other provision of law, both the county and the

health authority shall be eligible to receive funding under subdivision (p) of Section 14163.

(h) The county may terminate the health authority, but only by an ordinance approved by a two-thirds affirmative vote of the full board.

(i) Prior to the termination of the health authority, the county shall notify the department of its intent to terminate the health authority. The department shall conduct an audit of the health authority's records within 30 days of notification to determine the liabilities and assets of the health authority. The department shall report its findings to the county and to the Department of Managed Health Care within 10 days of completion of the audit. The county shall prepare a plan to liquidate or otherwise dispose of the assets of the health authority and to pay the liabilities of the health authority to the extent of the health authority's assets, and present the plan to the department and the Department of Managed Health Care within 30 days upon receipt of these findings.

(j) Any assets of the health authority derived from the contract entered into between the state and the authority pursuant to Article 2.97 (commencing with Section 14093), after payment of the liabilities of the health authority, shall be disposed of pursuant to the contract.

(k) (1) The governing body shall consist of 18 voting members, 14 of whom shall be appointed by resolution or ordinance of the board as follows:

(A) One member shall be a member of the board or any other person designated by the board.

(B) One member shall be a person who is employed in the senior management of a hospital not operated by the county or the University of California and who is nominated by the San Francisco Section of the Westbay Hospital Conference or any successor organization, or if there is no successor organization, a person who shall be nominated by the Hospital Council of Northern and Central California.

(C) Two members, one of whom shall be a person employed in the senior management of San Francisco General Hospital and one of whom shall be a person employed in the senior management of St. Luke's Hospital (San Francisco). If San Francisco General Hospital or St. Luke's Hospital, at the end of the term of the person appointed from its senior management, is not designated as a disproportionate share hospital, and if the governing body, after providing an opportunity for comment by the Westbay Hospital Conference, or any successor organization, determines that the hospital no longer serves an equivalent patient population, the governing body may, by a two-thirds vote of the full governing body, select an alternative hospital to nominate a person employed in its senior management to serve on the governing body. Alternatively, the governing body may approve a reduction in the

number of positions on the governing body as set forth in subdivision (p).

(D) Two members shall be employees in the senior management of either private nonprofit community clinics or a community clinic consortium, nominated by the San Francisco Community Clinic Consortium, or any successor organization.

(E) Two members shall be physicians, nominated by the San Francisco Medical Society, or any successor organization.

(F) One member shall be nominated by the San Francisco Labor Council, or any successor organization.

(G) Two members shall be persons nominated by the beneficiary committee of the health authority, at least one of whom shall, at the time of appointment and during the person's term, be a Medi-Cal beneficiary.

(H) Two members shall be persons knowledgeable in matters relating to either traditional safety net providers, health care organizations, the Medi-Cal program, or the activities of the health authority, nominated by the program committee of the health authority.

(I) One member shall be a person nominated by the San Francisco Pharmacy Leadership Group, or any successor organization.

(2) One member, selected to fulfill the appointments specified in subparagraph (A), (G), or (H) shall, in addition to representing his or her specified organization or employer, represent the discipline of nursing, and shall possess or be qualified to possess a registered nursing license.

(3) The initial members appointed by the board under the subdivision shall be, to the extent those individuals meet the qualifications set forth in this subdivision and are willing to serve, those persons who are members of the steering committee created by the county to develop the local initiative component of the Medi-Cal state plan in San Francisco. Following the initial staggering of terms, each of those members shall be appointed to a term of three years, except the member appointed pursuant to subparagraph (A) of paragraph (1), who shall serve at the pleasure of the board. At the first meeting of the governing body, the members appointed pursuant to this subdivision shall draw lots to determine seven members whose initial terms shall be for two years. Each member shall remain in office at the conclusion of that member's term until a successor member has been nominated and appointed.

(*l*) In addition to the requirements of subdivision (k), one member of the governing body shall be appointed by the Mayor of the City of San Francisco to serve at the pleasure of the mayor, one member shall be the county's director of public health or designee, who shall serve at the pleasure of that director, one member shall be the Chancellor of the University of California at San Francisco or his or her designee, who shall serve at the pleasure of the chancellor, and one member shall be the

county director of mental health or his or her designee, who shall serve at the pleasure of that director.

(m) There shall be one nonvoting member of the governing body who shall be appointed by, and serve at the pleasure of, the health commission of the county.

(n) Each person appointed to the governing body shall, throughout the member's term, either be a resident of the county or be employed within the geographic boundaries of the county.

(o) (1) The composition of the governing body and nomination process for appointment of its members shall be subject to alteration upon a two-thirds vote of the full membership of the governing body. This action shall be concurred in by a resolution or ordinance of the county.

(2) Notwithstanding paragraph (1), no alteration described in that paragraph shall cause the removal of a member prior to the expiration of that member's term.

(p) A majority of the members of the governing body shall constitute a quorum for the transaction of business, and all official acts of the governing body shall require the affirmative vote of a majority of the members present and voting. However, no official shall be approved with less than the affirmative vote of six members of the governing body, unless the number of members prohibited from voting because of conflicts of interest precludes adequate participation in the vote. The governing body may, by a two-thirds vote adopt, amend, or repeal rules and procedures for the governing body. Those rules and procedures may require that certain decisions be made by a vote that is greater than a majority vote.

(q) For purposes of Section 87103 of the Government Code, members appointed pursuant to subparagraphs (B) to (E), inclusive, of paragraph (1) of subdivision (k) represent, and are appointed to represent, respectively, the hospitals, private nonprofit community clinics, and physicians that contract with the health authority, or the health care service plan with which the health authority contracts, to provide health care services to the enrollees of the health authority or the health care service plan. Members appointed pursuant to subparagraphs (F) and (G) of paragraph (1) of subdivision (k) represent, and are appointed to represent, respectively, the health care workers and enrollees served by the health authority or its contracted health care service plan, and traditional safety net and ancillary providers and other organizations concerned with the activities of the health authority.

(r) A member of the governing body may be removed from office by the board by resolution or ordinance, only upon the recommendation of the health authority, and for any of the following reasons:

(1) Failure to retain the qualifications for appointment specified in subdivisions (k) and (n).

(2) Death or a disability that substantially interferes with the member's ability to carry out the duties of office.

(3) Conviction of any felony or a crime involving corruption.

(4) Failure of the member to discharge legal obligations as a member of a public agency.

(5) Substantial failure to perform the duties of office, including, but not limited to, unreasonable absence from meetings. The failure to attend three meetings in a row of the governing body, or a majority of the meetings in the most recent calendar year, may be deemed to be unreasonable absence.

(s) Any vacancy on the governing body, however created, shall be filled for the unexpired term by the board by resolution or ordinance. Each vacancy shall be filled by an individual having the qualifications of his or her predecessor, nominated as set forth in subdivision (k).

(t) The chair of the authority shall be selected by, and serve at the pleasure of, the governing body.

(u) The health authority shall establish all of the following:

(1) A beneficiary committee to advise the health authority on issues of concern to the recipients of services.

(2) A program committee to advise the health authority on matters relating to traditional safety net providers, ancillary providers, and other organizations concerned with the activities of the health authority.

(3) Any other committees determined to be advisable by the health authority.

(v) (1) Notwithstanding any provision of state or local law, including, but not limited to, the county charter, a member of the health authority shall not be deemed to be interested in a contract entered into by the authority within the meaning of Article 4 (commencing with Section 1090) of Chapter 1 of Division 4 of Title 1 of the Government Code, or within the meaning of conflict-of-interest restrictions in the county charter, if all of the following apply:

(A) The member does not influence or attempt to influence the health authority or another member of the health authority to enter into the contract in which the member is interested.

(B) The member discloses the interest to the health authority and abstains from voting on the contract.

(C) The health authority notes the member's disclosure and abstention in its official records and authorizes the contract in good faith by a vote of its membership sufficient for the purpose without counting the vote of the interested member.

(D) The member has an interest in or was appointed to represent the interests of physicians, health care practitioners, hospitals, pharmacies, or other health care organizations.

(E) The contract authorizes the member or the organization the member has an interest in or represents to provide services to beneficiaries under the authority's program or administrative services to the authority.

(2) In addition, no person serving as a member of the governing body shall, by virtue of that membership, be deemed to be engaged in activities that are inconsistent, incompatible, or in conflict with their duties as an officer or employee of the county or the University of California, or as an officer or an employee of any private hospital, clinic, or other health care organization. The membership shall not be deemed to be in violation of Section 1126 of the Government Code.

(w) Notwithstanding any other provision of law, those records of the health authority and of the county that reveal the authority's rates of payment for health care services or the health authority's deliberative processes, discussions, communications, or any other portion of the negotiations with providers of health care services for rates of payment, or the health authority's peer review proceedings shall not be required to be disclosed pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records. However, three years after a contract or amendment to a contract is fully executed, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(x) Notwithstanding any other provision of law, the health authority may meet in closed session to consider and take action on peer review proceedings and on matters pertaining to contracts and contract negotiations by the health authority's staff with providers of health care services concerning all matters relating to rates of payment. However, a decision as to whether to enter into, amend the services provisions of, or terminate, other than for reasons based upon peer review, a contract with a provider of health care services, shall be made in open session.

(y) (1) (A) Notwithstanding the Ralph M. Brown Act (Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code), the governing board of the health authority may meet in closed session for the purpose of discussion of, or taking action on matters involving, health authority trade secrets.

(B) The requirement that the authority make a public report of actions taken in closed session and the vote or abstention of every member present may be limited to a brief general description of the action taken and the vote so as to prevent the disclosure of a trade secret.

(C) For purposes of this subdivision, ‘‘health authority trade secret’’ means a trade secret, as defined in subdivision (d) of Section 3426.1 of the Civil Code, that also meets both of the following criteria:

(i) The secrecy of the information is necessary for the health authority to initiate a new service, program, marketing strategy, business plan, or technology, or to add a benefit or product.

(ii) Premature disclosure of the trade secret would create a substantial probability of depriving the health authority of a substantial economic benefit or opportunity.

(2) Those records of the health authority that reveal the health authority’s trade secrets are exempt from disclosure pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records. This exemption shall apply for a period of two years after the service, program, marketing strategy, business plan, technology, benefit, or product that is the subject of the trade secret is formally adopted by the governing body of the health authority, provided that the service, program, marketing strategy, business plan, technology, benefit, or product continues to be a trade secret. The governing board may delete the portion or portions containing trade secrets from any documents that were finally approved in the closed session held pursuant to this subdivision that are provided to persons who have made the timely or standing request.

(z) The health authority shall be deemed to be a public agency for purposes of all grant programs and other funding and loan guarantee programs.

(aa) Contracts under this article between the State Department of Health Services and the health authority shall be on a nonbid basis and shall be exempt from Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.

(ab) (1) The county controller or his or her designee, at intervals the county controller deems appropriate, shall conduct a review of the fiscal condition of the health authority, shall report the findings to the health authority and the board, and shall provide a copy of the findings to any public agency upon request.

(2) Upon the written request of the county controller, the health authority shall provide full access to the county controller all health authority records and documents as necessary to allow the county controller or designee to perform the activities authorized by this subdivision.

(ac) A Medi-Cal recipient receiving services through the health authority shall be deemed to be a subscriber or enrollee for purposes of Section 1379 of the Health and Safety Code.

SEC. 12.4. Section 14087.38 of the Welfare and Institutions Code is amended to read:

14087.38. (a) (1) In counties selected by the director with the concurrence of the county, a special county health authority may be established in order to meet the problems of delivery of publicly assisted medical care in each county, and to demonstrate ways of promoting quality care and cost efficiency. Nothing in this section shall be construed to preclude the department from expanding Medi-Cal managed care in ways other than those provided for in this section, including, but not limited to, the establishment of a public benefit corporation as set forth in Section 5110 of the Corporations Code.

(2) For purposes of this section, ''health authority'' means an entity separate from the county that meets the requirements of state and federal law and the quality, cost, and access criteria established by the department.

(b) The board of supervisors of a county described in subdivision (a) may, by ordinance, establish a health authority to negotiate and enter into contracts authorized by Section 14087.3, and to arrange for the provision of health care services provided pursuant to this chapter. If the board of supervisors elects to enact this ordinance, all rights, powers, duties, privileges, and immunities vested in a county contracting with the department under this article shall be vested in the health authority. The health authority may also enter into contracts for the provision of health care services to individuals including, but not limited to, those covered under Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, those entitled to coverage under other publicly supported programs, those employed by public agencies or private businesses, and uninsured or indigent individuals.

(c) The enabling ordinance shall specify the membership of the governing board of the health authority, the qualifications for individual members, the manner of appointment, selection, or removal of board members, and how long they shall serve, and any other matters the board of supervisors deems necessary or convenient for the conduct of the health authority's activities. Members of the governing board shall be appointed by the board of supervisors to represent the interests of the county, the general public, beneficiaries, physicians, hospitals, clinics, and other nonphysician health care providers. The health authority so established shall be considered an entity separate from the county and shall file a statement required by Section 53051 of the Government Code. The health authority shall have the power to acquire, possess, and dispose of real or personal property, as necessary for the performance of its functions, to employ personnel and contract for services required to meet its obligations, to sue or be sued, and to enter into agreements under

Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code. Any obligations of a health authority, statutory, contractual, or otherwise, shall be obligations solely of the health authority and shall not be the obligations of the county or of the state.

(d) Upon creation, the health authority may borrow from the county, and the county may lend the health authority funds or issue revenue anticipation notes to obtain those funds necessary to commence operations.

(e) Notwithstanding any other provision of law, both the county and the health authority shall be eligible to receive funding under subdivision (p) of Section 14163, and the health authority shall be considered to have satisfied the requirements of that subdivision.

(f) The health authority shall be deemed to be a public agency that is a unit of local government for purposes of all grant programs and other funding and loan guarantee programs.

(g) It is the intent of the Legislature that if a health authority is formed pursuant to this section, the county shall, with respect to its medical facilities and programs, occupy no greater or lesser status than any other health care provider in negotiating with the health authority for contracts to provide health care services. Nothing in this subdivision shall be construed to interfere with or limit the health authority in giving preference in negotiating to disproportionate share hospitals or other providers of health care to medically indigent or uninsured individuals.

(h) Notwithstanding any other provision of law, a member of the governing board of the health authority shall not be deemed to be interested in a contract entered into by the health authority within the meaning of Article 4 (commencing with Section 1090) of Chapter 1 of Division 4 of Title 1 of the Government Code if all the following apply:

(1) The member was appointed to represent the interests of physicians, health care practitioners, hospitals, pharmacies, or other health care organizations, or beneficiaries.

(2) The contract authorizes the member or the organization the member represents to provide services to beneficiaries under the health authority's programs.

(3) The contract contains substantially the same terms and conditions as contracts entered into with other individuals or organizations that the member was appointed to represent.

(4) The member does not influence or attempt to influence the health authority or another member of the health authority to enter into the contract in which the member is interested.

(5) The member discloses the interest to the health authority and abstains from voting on the contract.

(6) The governing board notes the member's disclosure and abstention in its official records and authorizes the contract in good faith by a vote of its membership sufficient for the purpose without counting the vote of the interested member.

(i) All claims for money or damages against the health authority shall be governed by Part 3 (commencing with Section 900) and Part 4 (commencing with Section 940) of Division 3.6 of Title 1 of the Government Code, except as provided by other statutes or regulations that expressly apply to the health authority.

(j) (1) The health authority shall be considered a public entity for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code.

(2) The health authority, members of its governing board, and its employees, are protected by the immunities applicable to public entities and public employees governed by Part 1 (commencing with Section 810) and Part 2 (commencing with Section 814) of Division 3.6 of Title 1 of the Government Code, except as provided by other statutes or regulations that apply expressly to the health authority.

(k) Notwithstanding any other provision of law, except as otherwise provided in this section, a county shall not be liable for any act or omission of the health authority.

(*l*) The transfer of responsibility for health care services to the health authority shall not relieve the county of its responsibility for indigent care pursuant to Section 17000.

(m) Notwithstanding any other provision of law, the governing board of the health authority may meet in closed session to consider and take action on matters pertaining to contracts, and to contract negotiations by health authority staff with providers of health care services concerning all matters related to rates of payment.

(n) (1) (A) Notwithstanding the Ralph M. Brown Act (Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of the Government Code), the governing board of the health authority may meet in closed session for the purpose of discussion of, or taking action on matters involving, health authority trade secrets.

(B) The requirement that the authority make a public report of actions taken in closed session and the vote or abstention of every member present may be limited to a brief general description of the action taken and the vote so as to prevent the disclosure of a trade secret.

(C) For purposes of this section, ''health authority trade secret'' means a trade secret, as defined in subdivision (d) of Section 3426.1 of the Civil Code, that also meets both of the following criteria:

(i) The secrecy of the information is necessary for the health authority to initiate a new service, program, marketing strategy, business plan, or technology, or to add a benefit or product.

(ii) Premature disclosure of the trade secret would create a substantial probability of depriving the health authority of a substantial economic benefit or opportunity.

(2) Those records of the health authority that reveal the health authority's trade secrets are exempt from disclosure pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records. This exemption shall apply for a period of two years after the service, program, marketing strategy, business plan, technology, benefit, or product that is the subject of the trade secret is formally adopted by the governing body of the health authority, provided that the service, program, marketing strategy, business plan, technology, benefit, or product continues to be a trade secret. The governing board may delete the portion or portions containing trade secrets from any documents that were finally approved in closed session held pursuant to this subdivision that are provided to persons who have made the timely or standing request.

(o) Notwithstanding Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of, and Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of, the Government Code, or any other provision of law, any peer review body, as defined in paragraph (1) of subdivision (a) of Section 805 of the Business and Professions Code, formed pursuant to the powers granted to the health authority authorized by this section, may, at its discretion and without notice to the public, meet in closed session, so long as the purpose of the meeting is the peer review body's discharge of its responsibility to evaluate and improve the quality of care rendered by health facilities and health practitioners, pursuant to the powers granted to the health authority. The peer review body and its members shall receive, to the fullest extent, all immunities, privileges, and protections available to those peer review bodies, their individual members, and persons or entities assisting in the peer review process, including those afforded by Section 1157 of the Evidence Code and Section 1370 of the Health and Safety Code.

(p) Notwithstanding any other provision of law, those records of the health authority and of the county that reveal the health authority's rates of payment for health care services or the health authority's deliberative processes, discussions, communications, or any other portion of the negotiations with providers of health care services for rates of payment, shall not be required to be disclosed pursuant to the California Public

Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), or any similar local law requiring the disclosure of public records. However, three years after a contract or amendment to a contract is fully executed, the portion of the contract or amendment containing the rates of payment shall be open to inspection.

(q) Notwithstanding the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), or Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of, and Chapter 9 (commencing with Section 54950) of Part 1 of Division 2 of Title 5 of, the Government Code, or any other provision of state or local law requiring disclosure of public records, those records of a peer review body, as defined in paragraph (1) of subdivision (a) of Section 805 of the Business and Professions Code, formed pursuant to the powers granted to the health authority authorized by this section, shall not be required to be disclosed. The records and proceedings of the peer review body and its individual members shall receive, to the fullest extent, all immunities, privileges, and protections available to those records and proceedings, including those afforded by Section 1157 of the Evidence Code and Section 1370 of the Health and Safety Code.

(r) Except as expressly provided by other provisions of this section, all exemptions and exclusions from disclosure as public records pursuant to the California Public Records Act, including, but not limited to, those pertaining to trade secrets and information withheld in the public interest, shall be fully applicable for all state agencies and local agencies with respect to all writings that the health authority is required to prepare, produce, or submit pursuant to this section.

(s) (1) Any health authority formed pursuant to this section shall obtain licensure as a health care service plan under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 3 of the Health and Safety Code).

(2) Notwithstanding subdivisions (b) and (t), a health authority may not operate health plans or programs for individuals covered under Subchapter XVIII (commencing with Section 1395) of Chapter 7 of Title 42 of the United States Code, or for private businesses, until the health authority is in full compliance with all of the requirements of the Knox-Keene Health Care Service Plan Act of 1975, including tangible net equity requirements applicable to a licensed health care service plan.

(t) Commencing on the date that the health authority first receives Medi-Cal capitated payments for the provision of health care services to Medi-Cal beneficiaries and until the time that the health authority is in compliance with all the requirements regarding tangible net equity applicable to a health care service plan licensed under the Knox-Keene

Health Care Service Plan Act of 1975, the following provisions shall apply:

(1) The health authority may select and design its automated management information system, but the department, in cooperation with the health authority, prior to making capitated payments, shall test the system to ensure that the system is capable of producing detailed, accurate, and timely financial information on the financial condition of the health authority and any other information generally required by the department in its contracts with health care service plans.

(2) In addition to the reports required by the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the Director of the Department of Managed Health Care promulgated thereunder, the health authority shall provide on a monthly basis to the department, the Department of Managed Health Care, and the members of the health authority, a copy of the automated report described in paragraph (1) and a projection of assets and liabilities, including those that have been incurred but not reported, with an explanation of material increases or decreases in current or projected assets or liabilities. The explanation of increases and decreases in assets or liabilities shall be provided, upon request, to a hospital, independent physicians' practice association, or community clinic, that has contracted with the health authority to provide health care services.

(3) In addition to the reporting and notification obligations the health authority has under the Knox-Keene Health Care Service Plan Act of 1975, the chief executive officer or director of the health authority shall immediately notify the department, the Department of Managed Health Care, and the members of the governing board of the health authority in writing of any fact or facts that, in the chief executive officer's or director's reasonable and prudent judgment, is likely to result in the health authority being unable to meet its financial obligations to health care providers or to other parties. Written notice shall describe the fact or facts, the anticipated fiscal consequences, and the actions that will be taken to address the anticipated consequences.

(4) The Department of Managed Health Care shall not waive or vary, nor shall the department request the Department of Managed Health Care to waive or vary, the tangible net equity requirements for a health authority under the Knox-Keene Health Care Service Plan Act of 1975 after three years from the date of commencement of capitated payments to the health authority. Until the time the health authority is in compliance with all of the tangible net equity requirements under the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the Director of the Department of Managed Health Care promulgated thereunder, the health authority shall develop a stop-loss program

appropriate to the risks of the health authority. The program shall be satisfactory to both the department and the Department of Managed Health Care.

(5) In the event that the health authority votes to file a petition of bankruptcy, or the board of supervisors notifies the department of its intent to terminate the health authority, the department shall immediately convert the authority's Medi-Cal beneficiaries to either of the following:

(A) To other managed care contractors when available, provided those contractors are able to demonstrate that they can absorb the increased enrollment without detriment to the provision of health care services to their existing enrollees.

(B) To the extent that other managed care contractors are unavailable or the department determines that the action is otherwise in the best interest of any particular beneficiary, to a fee-for-service reimbursement system pending the availability of managed care contractors, provided those contractors are able to demonstrate that they can absorb the increased enrollment without detriment to the provision of health care services to their existing enrollees, or if the department determines that providing care to any particular beneficiary pursuant to a fee-for-service reimbursement system is no longer necessary to protect the continuity of care or other interests of the beneficiary. Beneficiary eligibility for Medi-Cal shall not be affected by this action. Beneficiaries who have been or who are scheduled to be converted to a fee-for-service reimbursement system or managed care contractor may make a choice to be enrolled in another managed care system, if one is available, in full compliance with the federal freedom-of-choice requirements.

(6) The health authority shall submit to a review of financial records when the department determines, based on data reported by the health authority or otherwise, that the health authority will not be able to meet its financial obligations to health care providers contracting with the health authority. Where the review of financial records determines that the health authority will not be able to meet its financial obligations to contracting health care providers for the provision of health care services, the director shall immediately terminate the contract between the health authority and the state, and immediately convert the health authority Medi-Cal beneficiaries in accordance with paragraph (5) in order to ensure uninterrupted provision of health care services to the beneficiaries and to minimize financial disruption to providers. The action of the director shall be the final administrative determination. Beneficiary eligibility for Medi-Cal shall not be affected by this action. Beneficiaries who have been or who are scheduled to be converted under paragraph (5) may make a choice to be enrolled in another managed care

plan, if one is available, in full compliance with federal freedom-of-choice requirements.

(7) It is the intent of the Legislature that the department shall implement Medi-Cal capitated enrollments in a manner that ensures that appropriate levels of health care services will be provided to Medi-Cal beneficiaries and that appropriate levels of administrative services will be furnished to health care providers. The contract between the department and the health authority shall authorize and permit the department to administer the number of covered Medi-Cal enrollments in such a manner that the health authority's provider network and administrative structure are able to provide appropriate and timely services to beneficiaries and to participating providers.

(8) In the event a health authority is terminated, files for bankruptcy, or otherwise no longer functions for the purpose for which it was established, the county shall, with respect to compensation for provision of health care services to beneficiaries, occupy no greater or lesser status than any other health care provider in the disbursement of assets of the health authority.

(9) Nothing in this subdivision shall be construed to impair or diminish the authority of the Director of the Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975, nor shall anything in this section be construed to reduce or otherwise limit the obligation of a health authority licensed as a health care service plan to comply with the requirements of the Knox-Keene Health Care Service Plan Act of 1975, and the rules of the Director of the Department of Managed Health Care promulgated thereunder.

(u) In the event a health authority may no longer function for the purposes for which it is established, at the time the health authority's then-existing obligations have been satisfied or the health authority's assets have been exhausted, the board of supervisors may, by ordinance, terminate the health authority.

(v) (1) Prior to the termination of the health authority, the board of supervisors shall notify the department of its intent to terminate the health authority. The department shall conduct an audit of the health authority's records within 30 days of the notification to determine the liabilities and assets of the health authority.

(2) The department shall report its findings to the board within 10 days of completion of the audit. The board shall prepare a plan to liquidate or otherwise dispose of the assets of the health authority and to pay the liabilities of the health authority to the extent of the health authority's assets, and present the plan to the department within 30 days upon receipt of these findings.

(w) Any assets of the health authority shall be disposed of pursuant to provisions contained in the contract entered into between the state and the health authority pursuant to this section.

(x) Upon termination of a health authority by the board, the county shall manage any remaining assets of the health authority until superseded by a department-approved plan. Any liabilities of the health authority shall not become obligations of the county upon either the termination of the health authority or the liquidation or disposition of the health authority's remaining assets.

(y) This section shall apply to any county health authority or any county special commission operating under this article or Article 2.81 (commencing with Section 14087.96), except to the extent that this section conflicts with Sections 14087.31, 14087.35, and 14087.36 or Article 2.81 (commencing with Section 14087.96).

SEC. 12.5. Section 14087.51 of the Welfare and Institutions Code is amended to read:

14087.51. (a) It is necessary that a special commission be established in San Mateo County and in any other county designated by the California Medical Assistance Commission in order to meet the problems of the delivery of publicly assisted medical care in the counties and to demonstrate ways of promoting quality care and cost efficiency.

(b) The Board of Supervisors of San Mateo County and of the designated counties may, by ordinance, establish commissions to do any or all of the following:

(1) Negotiate the exclusive contracts specified in Section 14087.5 and to arrange for the provision of health care services provided pursuant to this chapter.

(2) Enter into contracts for the provision of health care services to subscribers in the Healthy Families Program.

(3) Enter into agreements under Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code.

(c) In addition to the authority specified in subdivision (b), the Board of Supervisors of San Mateo County may, by ordinance, authorize the commission established pursuant to this section to provide health care delivery systems for any or all of the following persons:

(1) Persons who are eligible to receive medical benefits under this chapter in the county, including, but not limited to, persons who are eligible through federal waiver or a pilot project.

(2) Persons who are eligible to receive medical benefits under both Title 18 and Title 19 of the federal Social Security Act.

(3) Persons who are eligible to receive medical benefits under Title 18 of the federal Social Security Act.

(4) Persons who are eligible to receive medical benefits under publicly supported programs if the commission and participating providers acting pursuant to subcontracts with the commission agree to hold harmless the beneficiaries of the publicly supported programs if the contract between the sponsoring government agency and the commission does not ensure sufficient funding to cover program costs.

(d) If the board of supervisors elects to enact an ordinance pursuant to this section, all rights, powers, duties, privileges, and immunities vested in a county by an article shall be vested in the county commission. Any reference in this article to ''county'' shall mean a commission established pursuant to this section.

(e) The enabling ordinance shall specify the membership of the county commission, the qualifications for individual members, and any other matters as the board of supervisors deems necessary or convenient for the conduct of the county commission's activities. A commission so established shall be considered a public entity for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code. All commissioners shall be appointed by majority vote of the board of supervisors and shall serve at the pleasure thereof. The board of supervisors may appoint no more than two of its own members to serve on the commission.

(f) As an alternative to establishing a separate commission, the enabling ordinance may designate the board of supervisors itself as the commission authorized by this article.

SEC. 12.6. Section 14087.54 of the Welfare and Institutions Code is amended to read:

14087.54. (a) Any county or counties may establish a special commission in order to meet the problems of the delivery of publicly assisted medical care in the county or counties and to demonstrate ways of promoting quality care and cost efficiency.

(b) A county board of supervisors may, by ordinance, establish a commission to negotiate the exclusive contract specified in Section 14087.5 and to arrange for the provision of health care services provided pursuant to this chapter. The boards of supervisors of more than one county may also establish a single commission with the authority to negotiate an exclusive contract and to arrange for the provision of services in those counties. If a board of supervisors elects to enact this ordinance, all rights, powers, duties, privileges, and immunities vested in a county by this article shall be vested in the county commission. Any reference in this article to ''county'' shall mean a commission established pursuant to this section.

(c) It is the intent of the Legislature that if a county forms a commission pursuant to this section, the county shall, with respect to its

medical facilities and programs occupy no greater or lesser status than any other health care provider in negotiating with the commission for contracts to provide health care services.

(d) The enabling ordinance shall specify the membership of the county commission, the qualifications for individual members, the manner of appointment, selection, or removal of commissioners, and how long they shall serve, and any other matters as a board of supervisors deems necessary or convenient for the conduct of the county commission's activities. A commission so established shall be considered an entity separate from the county or counties, shall be considered a public entity for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code, and shall file the statement required by Section 53051 of the Government Code. The commission shall have in addition to the rights, powers, duties, privileges, and immunities previously conferred, the power to acquire, possess, and dispose of real or personal property, as may be necessary for the performance of its functions, to employ personnel and contract for services required to meet its obligations, to sue or be sued, and to enter into agreements under Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code. Any obligations of a commission, statutory, contractual, or otherwise, shall be the obligations solely of the commission and shall not be the obligations of the county or of the state.

(e) Upon creation, a commission may borrow from the county or counties, and the county or counties may lend the commission funds, or issue revenue anticipation notes to obtain those funds necessary to commence operations.

(f) In the event a commission may no longer function for the purposes for which it was established, at such time as the commission's then existing obligations have been satisfied or the commission's assets have been exhausted, the board or boards of supervisors may by ordinance terminate the commission.

(g) Prior to the termination of a commission, the board or boards of supervisors shall notify the State Department of Health Services of its intent to terminate the commission. The department shall conduct an audit of the commission's records within 30 days of the notification to determine the liabilities and assets of the commission. The department shall report its findings to the board or boards within 10 days of completion of the audit. The board or boards shall prepare a plan to liquidate or otherwise dispose of the assets of the commission and to pay the liabilities of the commission to the extent of the commission's assets, and present the plan to the department within 30 days upon receipt of these findings.

(h) Upon termination of a commission by the board or boards, the county or counties shall manage any remaining assets of the commission until superseded by a department approved plan. Any liabilities of the commission shall not become obligations of the county or counties upon either the termination of the commission or the liquidation or disposition of the commission's remaining assets.

(i) Any assets of a commission shall be disposed of pursuant to provisions contained in the contract entered into between the state and the commission pursuant to this article.

SEC. 12.7. Section 14087.9605 of the Welfare and Institutions Code is amended to read:

14087.9605. (a) The board of supervisors may, by ordinance, resolution, or other action, establish a commission in order to meet the problems of delivery of publicly assisted medical care in the county and demonstrate ways of promoting quality care and cost efficiency. The health care services provided by the commission shall include, but are not limited to, services covered under this chapter provided on a coordinated managed care basis. The commission shall operate the local initiative that provides or arranges for the delivery of health care services in all or part of the geographic area of the county, in a manner that is consistent with managed care principles, techniques, and practices directed at ensuring cost-effective and adequate access to quality care, without discrimination on the basis of medical condition, diagnosis, or illness, in an amount, duration, and scope that is sufficient to reasonably achieve its purpose for enrollees in the local initiative. If the board of supervisors establishes a commission, all rights, powers, duties, privileges, and immunities vested in the county pursuant to the contract with the department under this article shall be vested in the commission.

(b) (1) The commission shall be considered a public entity that is a local unit of government and that is separate from the county, shall file the statement required by Section 53051 of the Government Code, and shall be considered a public entity for purposes of Division 3.6 (commencing with Section 810) of Title 1 of the Government Code. The commission, members of the commission, and employees of the commission shall be protected by the immunities applicable to public entities and public employees governed by Part 2 (commencing with Section 814) of Division 3.6 of Title 1 of the Government Code, except as provided by other statutes or regulations that apply expressly to the commission.

(2) The commission shall have all power necessary and appropriate to do all of the following:

(A) Operate programs involving health care services, including, but not limited to, the power to own and operate one or more health plans.

(B) To enter into agreements with any public or private entity or entities to provide or arrange for health care services on a capitated or noncapitated basis.

(C) To acquire, possess, and dispose of real or personal property.

(D) To employ personnel and contract for services required to meet its obligations.

(E) To sue or be sued.

(F) To enter into agreements under Chapter 5 (commencing with Section 6500) of Division 7 of Title 1 of the Government Code.

(3) The commission may enter into contracts with public and private health care providers to provide health care and related services to individuals enrolled in any health plan or health program operated as part of the local initiative.

(c) Nothing in this section shall be construed to authorize the commission to operate any health care program other than the local initiative described in the strategic plan as it currently exists or as it may be amended by the department.

SEC. 13. Section 14094.3 of the Welfare and Institutions Code is amended to read:

14094.3. (a) Notwithstanding this article or Section 14093.05 or 14094.1, CCS covered services shall not be incorporated into any Medi-Cal managed care contract entered into after August 1, 1994, pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.9 (commencing with Section 14088), Article 2.91 (commencing with Section 14089), Article 2.95 (commencing with Section 14092); or either Article 2 (commencing with Section 14200), or Article 7 (commencing with Section 14490) of Chapter 8, until September 1, 2008, except for contracts entered into for county organized health systems or Regional Health Authority in the Counties of San Mateo, Santa Barbara, Solano, Yolo, Marin, and Napa.

(b) Notwithstanding any other provision of this chapter, providers serving children under the CCS program who are enrolled with a Medi-Cal managed care contractor but who are not enrolled in a pilot project pursuant to subdivision (c) shall continue to submit billing for CCS covered services on a fee-for-service basis until CCS covered services are incorporated into the Medi-Cal managed care contracts described in subdivision (a).

(c) (1) The department may authorize a pilot project in Solano County in which reimbursement for conditions eligible under the CCS program may be reimbursed on a capitated basis pursuant to Section 14093.05, and provided all CCS program's guidelines, standards, and

regulations are adhered to, and CCS program's case management is utilized.

(2) During the time period described in subdivision (a), the department may approve, implement, and evaluate limited pilot projects under the CCS program to test alternative managed care models tailored to the special health care needs of children under the CCS program. The pilot projects may include, but need not be limited to, coverage of different geographic areas, focusing on certain subpopulations, and the employment of different payment and incentive models. Pilot project proposals from CCS program-approved providers shall be given preference. All pilot projects shall utilize CCS program-approved standards and providers pursuant to Section 14094.1.

(d) (1) The department shall submit to the appropriate committees of the Legislature an evaluation of pilot projects established pursuant to subdivision (c) based on at least one full year of operation.

(2) The evaluation required by paragraph (1) shall address the impact of the pilot projects on outcomes as set forth in paragraph (4) and, in addition, shall do both of the following:

(A) Examine the barriers, if any, to incorporating CCS covered services into the Medi-Cal managed care contracts described in subdivision (a).

(B) Compare different pilot project models with the fee-for-service system. The evaluation shall identify, to the extent possible, those factors that make pilot projects most effective in meeting the special needs of children with CCS eligible conditions.

(3) CCS covered services shall not be incorporated into the Medi-Cal managed care contracts described in subdivision (a) before the evaluation process has been completed.

(4) The pilot projects shall be evaluated to determine if:

(A) All children enrolled with a Medi-Cal managed care contractor described in subdivision (a) identified as having a CCS eligible condition are referred in a timely fashion for appropriate health care.

(B) All children in the CCS program have access to coordinated care that includes primary care services in their own community.

(C) CCS program standards are adhered to.

(e) For purposes of this section, CCS covered services include all program benefits administered by the program specified in Section 123840 of the Health and Safety Code regardless of the funding source.

(f) Nothing in this section shall be construed to exclude or restrict CCS eligible children from enrollment with a managed care contractor, or from receiving from the managed care contractor with which they are enrolled primary and other health care unrelated to the treatment of the CCS eligible condition.

SEC. 13.5. Section 14105.19 of the Welfare and Institutions Code is amended to read:

14105.19. (a) Due to the significant state budget deficit projected for the 2003–04 fiscal year, and in order to implement changes in the level of funding for health care services, the Director of Health Services shall reduce provider payments as specified in this section.

(b) (1) Payments shall be reduced by 5 percent for Medi-Cal program services for dates of service on and after January 1, 2004.

(2) Payments shall be reduced by 5 percent for non-Medi-Cal programs described in Section 14105.18, for dates of service on and after January 1, 2004.

(3) The payments made to managed health care plans shall be reduced by the actuarial equivalent amount of 5 percent at the time of the plan's next rate determination.

(4) Reductions to payments for durable medical equipment shall be made at the discretion of the director. If any reduction is made pursuant to this paragraph, the reduction may not exceed 5 percent.

(c) The services listed below shall be exempt from the payment reductions specified in subdivision (b):

(1) Acute hospital inpatient services.

(2) Federally qualified health clinic services.

(3) Rural health clinic services.

(4) Outpatient services billed by a hospital.

(5) Payments to state hospitals or developmental centers.

(6) Payments to long-term care facilities as defined by the department, including, but not limited to, freestanding nursing facilities, distinct-part nursing facilities, intermediate care facilities for developmentally disabled individuals, subacute care units of skilled nursing facilities, rural swing beds, ventilator weaning services, special treatment program services, adult day health care centers, and hospice room and board services.

(7) Clinical laboratory or laboratory services as defined in Section 51137.2 of Title 22 of the California Code of Regulations.

(8) Contract services as designated by the Director of Health Services pursuant to subdivision (e).

(9) Supplemental reimbursement provided pursuant to Sections 14105.27, 14105.95, and 14105.96.

(10) Services provided on or after July 1, 2004, through the California Children's Services Program pursuant to Article 5 (commencing with Section 123800) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, the Genetically Handicapped Persons Program, pursuant to Article 1 (commencing with Section 125125) of Chapter 2 of Part 5 of Division 106 of the Health and Safety Code, the Child Health and

Disability Prevention Program pursuant to Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, the Multipurpose Senior Services Program pursuant to Chapter 8 (commencing with Section 9560) of Division 8.5, the Breast and Cervical Cancer Early Detection Program established pursuant to Article 1.3 (commencing with Section 104150) of Chapter 2 of Part 1 of Division 103 of the Health and Safety Code, and the breast cancer programs specified in Section 30461.6 of the Revenue and Taxation Code.

(11) Legend and nonlegend drugs dispensed by pharmacy providers reimbursed pursuant to Section 14105.45, effective September 1, 2004.

(d) Subject to the exception for services listed in subdivision (c), the payment reductions required by subdivision (b) shall apply to the services rendered by any provider who may be authorized to bill for the service, including, but not limited to, physicians, podiatrists, nurse practitioners, certified nurse midwives, nurse anesthetists, and organized outpatient clinics.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of provider bulletin, or similar instruction, without taking regulatory action.

(f) The department shall promptly seek all necessary federal approvals in order to implement this section, including necessary amendments to the state plan.

(g) This section shall remain in effect only until January 1, 2007, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2007, deletes or extends that date.

SEC. 14. Section 14105.336 of the Welfare and Institutions Code is amended to read:

14105.336. (a) The department shall reduce reimbursements to pharmacists by fifty cents ($0.50) per prescription, effective January 1, 1995, for all drug prescription claims reimbursed through the Medi-Cal program.

(b) This section shall become inoperative on September 1, 2004.

SEC. 15. Section 14105.337 of the Welfare and Institutions Code is amended to read:

14105.337. (a) Effective January 1, 2000, the department shall increase reimbursement to pharmacists by twenty-five cents ($0.25) per prescription for all drug prescription claims reimbursed through the Medi-Cal program.

(b) Effective July 1, 2002, the department shall increase reimbursement to pharmacists by an additional fifteen cents ($0.15) per

prescription for all drug prescription claims reimbursed through the Medi-Cal program.

(c) (1) The department shall reduce reimbursement to pharmacists in the amount reimbursement was increased pursuant to subdivisions (a) and (b) with respect to pharmacy services rendered on and after the date that this subdivision is enacted. Claims submitted by pharmacists for beneficiaries residing in a nursing facility shall be exempt from this subdivision.

(2) This subdivision shall become inoperative on July 1, 2004.

(d) This section shall become inoperative on September 1, 2004.

SEC. 16. Section 14105.45 of the Welfare and Institutions Code is repealed.

SEC. 17. Section 14105.45 is added to the Welfare and Institutions Code, to read:

14105.45. (a) For purposes of this section, the following definitions shall apply:

(1) ''Average sales price'' means, of a drug or biological, the sales price for a National Drug Code for a calendar quarter for a manufacturer for a unit, calculated as follows:

(A) The manufacturer's sales to all purchasers, excluding sales exempt under subparagraph (B), of a drug or biological in the United States in the calendar quarter, divided by the total number of the units of that drug or biological sold by the manufacturer in that calendar quarter.

(B) In calculating the manufacturer's average sales price, the following sales shall be excluded:

(i) Sales exempt from inclusion in the determination of ''best price'' under Section 1927(c)(1)(C)(i) of the Social Security Act (42 U.S.C. Sec. 1396r-8(c)(1)(C)(i)).

(ii) Any other sales as the Secretary of the United States Department of Health and Human Services identifies as sales to an entity that are merely nominal in amount, as applied for purposes of Section 1927(c)(1)(C)(ii)(III) of the Social Security Act (42 U.S.C. Sec. 1396r-8(c)(1)(C)(ii)(III)), except as the secretary may otherwise provide.

(C) In calculating the manufacturer's average sales price, the price shall include volume discounts, prompt pay discounts, cash discounts, free goods that are contingent on any purchase requirement, chargebacks, and rebates, other than rebates under Section 1927 of the Social Security Act (42 U.S.C. Sec. 1396r-8). After 2004, the secretary may include in the manufacturer's average sales price other price concessions, which may be based on recommendations of the Inspector

General of the United States Department of Health and Human Services, that would result in a reduction of the cost to the purchaser.

(D) In the case of a drug or biological during an initial period, not to exceed a full calendar quarter, in which data on the prices for sales for the drug or biological are not sufficiently available from the manufacturer to compute an average sales price for the drug or biological, the department may determine the amount payable under this section for the drug or biological based on the wholesale selling price.

(2) ''Average wholesale price'' means the price for a drug product listed in the department's primary price reference source.

(3) ''Direct price'' means the price for a drug product purchased by a pharmacy directly from a drug manufacturer listed in the department's primary reference source.

(4) ''Estimated acquisition cost'' means the department's best estimate of the price generally and currently paid by providers for a drug product sold by a particular manufacturer or principal labeler in a standard package.

(5) ''Federal upper limit'' means the maximum per unit reimbursement when established by the Centers for Medicare and Medicaid Services and published by the department in Medi-Cal pharmacy provider bulletins and manuals.

(6) ''Generically equivalent drugs'' means drug products with the same active chemical ingredients of the same strength, quantity, and dosage form, and of the same generic drug name, as determined by the United States Adopted Names (USAN) and accepted by the federal Food and Drug Administration (FDA), as those drug products having the same chemical ingredients.

(7) ''Legend drug'' means any drug whose labeling states ''Caution: Federal law prohibits dispensing without prescription,'' ''Rx only,'' or words of similar import.

(8) ''Maximum allowable ingredient cost'' (MAIC) means the maximum amount the department will reimburse Medi-Cal pharmacy providers for generically equivalent drugs.

(9) ''Innovator multiple source drug,'' ''noninnovator multiple source drug,'' and ''single source drug'' have the same meaning as those terms are defined in Section 1396r-8(k)(7) of Title 42 of the United States Code.

(10) ''Nonlegend drug'' means any drug whose labeling does not contain the statement referenced in paragraph (7).

(11) ''Wholesale selling price'' means the weighted (by unit volume) mean price, including discounts and rebates, paid by a pharmacy to a wholesale drug distributor.

(12) ‘‘Selling price’’ means the price used in the establishment of the estimated acquisition cost. The department shall base the selling price on the average sales price reported by manufacturers pursuant to subdivision (c). The selling price shall not be considered confidential and shall be subject to disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(b) (1) Reimbursement to Medi-Cal pharmacy providers for legend and nonlegend drugs shall consist of the estimated acquisition cost of the drug plus a professional fee for dispensing. The professional fee shall be seven dollars and twenty-five cents ($7.25) per dispensed prescription. The professional fee for legend drugs dispensed to a beneficiary residing in a skilled nursing facility or intermediate care facility shall be eight dollars ($8) per dispensed prescription. For purposes of this paragraph ‘‘skilled nursing facility’’ and ‘‘intermediate care facility’’ shall have the same meaning as defined in Division 5 (commencing with Section 70001) of Title 22 of the California Code of Regulations.

(2) The department shall establish the estimated acquisition cost of legend and nonlegend drugs as follows:

(A) For single source and innovator multiple source drugs, the estimated acquisition cost shall be equal to the lowest of the average wholesale price minus 17 percent, the selling price, the federal upper limit, or the MAIC.

(B) For noninnovator multiple source drugs, the estimated acquisition cost shall be equal to the lowest of the average wholesale price minus 17 percent, the selling price, the federal upper limit, or the MAIC.

(C) The department shall not use the direct price paid by pharmacies to drug manufacturers to establish estimated acquisition cost.

(3) For purposes of paragraph (2), the department shall establish a list of MAICs for generically equivalent drugs, which shall be published in pharmacy provider bulletins and manuals. The department shall update the list of MAICs and establish additional MAICs in accordance with all of the following:

(A) The department shall base the MAIC on the mean of the wholesale selling prices of drugs generically equivalent to the particular innovator drug that are available in California from wholesale drug distributors selected by the department.

(B) The department shall notify each selected wholesale drug distributor, in writing, that the wholesale drug distributor has been identified as a source of wholesale selling price information.

(C) Wholesale drug distributors notified pursuant to subparagraph (B) shall, no later than 30 days after the end of each month, and in a

format determined by the department, provide to the department the wholesale selling price of all legend and nonlegend drugs sold to pharmacies.

(D) The department shall update MAICs at least every three months and notify Medi-Cal providers at least 30 days prior to the effective date of a MAIC.

(E) The failure of a wholesaler to report wholesale selling prices pursuant to subparagraph (C) of paragraph (3) of subdivision (b) shall result in the director denying payment for all drugs supplied by that wholesaler to Medi-Cal program beneficiaries. The denial of payment shall be effective no sooner than 30 days after notifying pharmacy providers of the change through a provider bulletin.

(F) All pricing information reported by a wholesale distributor to the department pursuant to this section shall be considered confidential and corporate proprietary information and shall not be subject to disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(c) (1) Manufacturers and principal labelers of legend and nonlegend drugs shall, no later than 30 days after the end of each calendar quarter, and in a format determined by the department, provide to the department the average sales price of each of the manufacturer's legend and nonlegend drugs.

(2) The department shall update the Medi-Cal claims processing system to reflect the selling price of drugs not later than 62 calendar days after the end of each calendar quarter.

(3) For manufacturers that fail to provide average selling price information pursuant to this section, the department may subject their drugs' availability to prior authorization. The provisions of this subdivision shall be included in contracts or contract amendments entered into by the department pursuant to Section 14105.3, 14105.33, 14105.37, or 14105.39, and manufacturers shall continue rebate payments according to the rebate provisions in the contracts. Nothing in this paragraph shall affect a Medi-Cal beneficiary's ability to receive continuity of care for 60 days as contained in subdivision (i) of Section 14105.33.

(4) All pricing information reported by manufacturers and principal labelers of legend and nonlegend drugs to the department pursuant to this section shall be considered confidential and corporate proprietary information and shall not be subject to disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code.

(d) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department

may take the actions specified in this section by means of a provider bulletin or notice, policy letter, or other similar instructions, without taking regulatory action.

SEC. 18. Section 14105.46 of the Welfare and Institutions Code is repealed.

SEC. 18.5. Section 14110.65 of the Welfare and Institutions Code is repealed.

SEC. 19. Section 14132.100 of the Welfare and Institutions Code is amended to read:

14132.100. (a) The federally qualified health center services described in Section 1396d(a)(2)(C) of Title 42 of the United States Code are covered benefits.

(b) The rural health clinic services described in Section 1396d (a)(2)(B) of Title 42 of the United States Code are covered benefits.

(c) Federally qualified health center services and rural health clinic services shall be reimbursed on a per-visit basis in accord with the definition of ''visit'' set forth in subdivision (g).

(d) Effective October 1, 2004, and on each October 1, thereafter, until no longer required by federal law, federally qualified health center (FQHC) and rural health clinic (RHC) per-visit rates shall be increased by the Medicare Economic Index applicable to primary care services in the manner provided for in Section 1396a(bb)(3)(A) of Title 42 of the United States Code. Prior to January 1, 2004, FQHC and RHC per-visit rates shall be adjusted by the Medicare Economic Index in accord with the methodology set forth in the state plan in effect on October 1, 2001.

(e) (1) An FQHC or RHC may apply for an adjustment to its per-visit rate based on a change in the scope of services provided by the FQHC or RHC. Rate changes based on a change in the scope of services provided by an FQHC or RHC shall be evaluated in accordance with Medicare reasonable cost principles, as set forth in Part 413 (commencing with Section 413.1) of Title 42 of the Code of Federal Regulations, or its successor.

(2) Subject to the conditions set forth in subparagraphs (A) to (D), inclusive, of paragraph (3), a change in scope of service means any of the following:

(A) The addition of a new FQHC or RHC service that is not incorporated in the baseline prospective payment system (PPS) rate, or a deletion of an FQHC or RHC service that is incorporated in the baseline PPS rate.

(B) A change in service due to amended regulatory requirements or rules.

(C) A change in service resulting from relocating or remodeling an FQHC or RHC.

(D) A change in types of services due to a change in applicable technology and medical practice utilized by the center or clinic.

(E) An increase in service intensity attributable to changes in the types of patients served, including, but not limited to, populations with HIV or AIDS, or other chronic diseases, or homeless, elderly, migrant, or other special populations.

(F) Any changes in any of the services described in subdivision (a) or (b), or in the provider mix of an FQHC or RHC or one of its sites.

(G) Changes in operating costs attributable to capital expenditures associated with a modification of the scope of any of the services described in subdivisions (a) or (b), including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the center or clinic.

(H) Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and residents.

(I) Any changes in the scope of a project approved by the federal Health Resources and Service Administration (HRSA).

(3) No change in costs shall, in and of itself, be considered a scope-of-service change unless all of the following apply:

(A) The increase or decrease in cost is attributable to an increase or decrease in the scope of services defined in subdivisions (a) and (b), as applicable.

(B) The cost is allowable under Medicare reasonable cost principles set forth in Part 413 (commencing with Section 413) of Subchapter B of Chapter 4 of Title 42 of the Code of Federal Regulations, or its successor.

(C) The change in the scope of services is a change in the type, intensity, duration, or amount of services, or any combination thereof.

(D) The net change in the FQHC's or RHC's rate equals or exceeds 1.75 percent for the affected FQHC or RHC site. For FQHCs and RHCs that filed consolidated cost reports for multiple sites to establish the initial prospective payment reimbursement rate, the 1.75 percent threshold shall be applied to the average per-visit rate of all sites for the purposes of calculating the cost associated with a scope-of-service change. ''Net change'' means the per-visit rate change attributable to the cumulative effect of all increases and decreases for a particular fiscal year.

(4) An FQHC or RHC may submit requests for scope-of-service changes once per fiscal year, only within 90 days following the beginning of the FQHC's or RHC's fiscal year. Any approved increase or decrease in the provider's rate shall be retroactive to the beginning of the FQHC's or RHC's fiscal year in which the request is submitted.

(5) An FQHC or RHC shall submit a scope-of-service rate change request within 90 days of the beginning of any FQHC or RHC fiscal year occurring after the effective date of this section, if, during the FQHC's or RHC's prior fiscal year, the FQHC or RHC experienced a decrease in the scope of services provided that the FQHC or RHC either knew or should have known would have resulted in a significantly lower per-visit rate. If an FQHC or RHC discontinues providing onsite pharmacy or dental services, it shall submit a scope-of-service rate change request within 90 days of the beginning of the following fiscal year. The rate change shall be effective as provided for in paragraph (4). As used in this paragraph, ''significantly lower'' means an average per-visit rate decrease in excess of 2.5 percent.

(6) Notwithstanding paragraph (4), if the approved scope-of-service change or changes were initially implemented on or after the first day of an FQHC's or RHC's fiscal year ending in calendar year 2001, but before the adoption and issuance of written instructions for applying for a scope-of-service change, the adjusted reimbursement rate for that scope-of-service change shall be made retroactive to the date the scope-of-service change was initially implemented. Scope-of-service changes under this paragraph shall be required to be submitted within the later of 150 days after the adoption and issuance of the written instructions by the department, or 150 days after the end of the FQHC's or RHC's fiscal year ending in 2003.

(7) All references in this subdivision to ''fiscal year'' shall be construed to be references to the fiscal year of the individual FQHC or RHC, as the case may be.

(f) (1) An FQHC or RHC may request a supplemental payment if extraordinary circumstances beyond the control of the FQHC or RHC occur after December 31, 2001, and PPS payments are insufficient due to these extraordinary circumstances. Supplemental payments arising from extraordinary circumstances under this subdivision shall be solely and exclusively within the discretion of the department and shall not be subject to subdivision (*l*). These supplemental payments shall be determined separately from the scope-of-service adjustments described in subdivision (e). Extraordinary circumstances include, but are not limited to, acts of nature, changes in applicable requirements in the Health and Safety Code, changes in applicable licensure requirements, and changes in applicable rules or regulations. Mere inflation of costs alone, absent extraordinary circumstances, shall not be grounds for supplemental payment. If an FQHC's or RHC's PPS rate is sufficient to cover its overall costs, including those associated with the extraordinary circumstances, then a supplemental payment is not warranted.

(2) The department shall accept requests for supplemental payment at any time throughout the prospective payment rate year.

(3) Requests for supplemental payments shall be submitted in writing to the department and shall set forth the reasons for the request. Each request shall be accompanied by sufficient documentation to enable the department to act upon the request. Documentation shall include the data necessary to demonstrate that the circumstances for which supplemental payment is requested meet the requirements set forth in this section. Documentation shall include all of the following:

(A) A presentation of data to demonstrate reasons for the FQHC's or RHC's request for a supplemental payment.

(B) Documentation showing the cost implications. The cost impact shall be material and significant (two hundred thousand dollars ($200,000) or 1 percent of a facility's total costs, whichever is less).

(4) A request shall be submitted for each affected year.

(5) Amounts granted for supplemental payment requests shall be paid as lump-sum amounts for those years and not as revised PPS rates, and shall be repaid by the FQHC or RHC to the extent that it is not expended for the specified purposes.

(6) The department shall notify the provider of the department's discretionary decision in writing.

(g) An FQHC or RHC ''visit'' means a face-to-face encounter between an FQHC or RHC patient and a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, or a visiting nurse. For purposes of this section, ''physician'' shall be interpreted in a manner consistent with the Centers for Medicare and Medicaid Services' Medicare Rural Health Clinic and Federally Qualified Health Center Manual (Publication 27), or its successor, only to the extent that it defines the professionals whose services are reimbursable on a per-visit basis and not as to the types of services that these professionals may render during these visits and shall include a medical doctor, osteopath, podiatrist, dentist, optometrist, and chiropractor. A visit shall also include a face-to-face encounter between an FQHC or RHC patient and a comprehensive perinatal services practitioner, as defined in Section 51179.1 of Title 22 of the California Code of Regulations, providing comprehensive perinatal services, a four-hour day of attendance at an adult day health care center, and any other provider identified in the state plan's definition of an FQHC or RHC visit.

(h) If FQHC or RHC services are partially reimbursed by a third-party payer, such as a managed care entity (as defined in Section 1396u-2(a)(1)(B) of Title 42 of the United States Code), the Medicare program, or the Child Health and Disability Prevention (CHDP)

program, the department shall reimburse an FQHC or RHC for the difference between its per-visit PPS rate and receipts from other plans or programs on a contract-by-contract basis and not in the aggregate, and may not include managed care financial incentive payments that are required by federal law to be excluded from the calculation.

(i) (1) An entity that first qualifies as an FQHC or RHC in the year 2001 or later, a newly licensed facility at a new location added to an existing FQHC or RHC, and any entity that is an existing FQHC or RHC that is relocated to a new site shall each have its reimbursement rate established in accordance with one of the following methods, as selected by the FQHC or RHC:

(A) The rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or adjacent area with a similar caseload.

(B) In the absence of three comparable FQHCs or RHCs with a similar caseload, the rate may be calculated on a per-visit basis in an amount that is equal to the average of the per-visit rates of three comparable FQHCs or RHCs located in the same or an adjacent service area, or in a reasonably similar geographic area with respect to relevant social, health care, and economic characteristics.

(C) At a new entity's one-time election, the department shall establish a reimbursement rate, calculated on a per-visit basis, that is equal to 100 percent of the projected allowable costs to the FQHC or RHC of furnishing FQHC or RHC services during the first 12 months of operation as an FQHC or RHC. After the first 12-month period, the projected per-visit rate shall be increased by the Medicare Economic Index then in effect. The projected allowable costs for the first 12 months shall be cost settled and the prospective payment reimbursement rate shall be adjusted based on actual and allowable cost per visit.

(D) The department may adopt any further and additional methods of setting reimbursement rates for newly qualified FQHCs or RHCs as are consistent with Section 1396a(bb)(4) of Title 42 of the United States Code.

(2) In order for an FQHC or RHC to establish the comparability of its caseload for purposes of subparagraph (A) or (B) of paragraph (1), the department shall require that the FQHC or RHC submit its most recent annual utilization report as submitted to the Office of Statewide Health Planning and Development, unless the FQHC or RHC was not required to file an annual utilization report. FQHCs or RHCs that have experienced changes in their services or caseload subsequent to the filing of the annual utilization report may submit to the department a completed report in the format applicable to the prior calendar year. FQHCs or RHCs that have not previously submitted an annual

utilization report shall submit to the department a completed report in the format applicable to the prior calendar year. The FQHC or RHC shall not be required to submit the annual utilization report for the comparable FQHCs or RHCs to the department, but shall be required to identify the comparable FQHCs or RHCs.

(3) The rate for any newly qualified entity set forth under this subdivision shall be effective retroactively to the later of the date that the entity was first qualified by the applicable federal agency as an FQHC or RHC, the date a new facility at a new location was added to an existing FQHC or RHC, or the date on which an existing FQHC or RHC was relocated to a new site. The FQHC or RHC shall be permitted to continue billing for Medi-Cal covered benefits on a fee-for-service basis under its existing provider number until it is informed of its new FQHC or RHC provider number, and the department shall reconcile the difference between the fee-for-service payments and the FQHC's or RHC's prospective payment rate at that time.

(j) Visits occurring at an intermittent clinic site, as defined in subdivision (h) of Section 1206 of the Health and Safety Code, of an existing FQHC or RHC, or in a mobile unit as defined by paragraph (2) of subdivision (b) of Section 1765.105 of the Health and Safety Code, shall be billed by and reimbursed at the same rate as the FQHC or RHC establishing the intermittent clinic site or the mobile unit, subject to the right of the FQHC or RHC to request a scope-of-service adjustment to the rate.

(k) An FQHC or RHC may elect to have pharmacy or dental services reimbursed on a fee-for-service basis, utilizing the current fee schedules established for those services. These costs shall be adjusted out of the FQHC's or RHC's clinic base rate as scope-of-service changes. An FQHC or RHC that reverses its election under this subdivision shall revert to its prior rate, subject to an increase to account for all MEI increases occurring during the intervening time period, and subject to any increase or decrease associated with applicable scope-of-services adjustments as provided in subdivision (e).

(*l*) FQHCs and RHCs may appeal a grievance or complaint concerning ratesetting, scope-of-service changes, and settlement of cost report audits, in the manner prescribed by Section 14171. The rights and remedies provided under this subdivision are cumulative to the rights and remedies available under all other provisions of law of this state.

(m) The department shall, by no later than March 30, 2004, promptly seek all necessary federal approvals in order to implement this section, including any amendments to the state plan. To the extent that any element or requirement of this section is not approved, the department shall submit a request to the federal Centers for Medicare and Medicaid

Services for any waivers that would be necessary to implement this section.

(n) The department shall implement this section only to the extent that federal financial participation is obtained.

SEC. 20. Section 14132.105 is added to the Welfare and Institutions Code, to read:

14132.105. (a) The department may adopt emergency regulations to implement Section 14132.100 in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(b) The adoption of emergency regulations described in subdivision (a) shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. The emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and Publication in the California Code of Regulations.

(c) Notwithstanding subdivisions (a) and (b), the director may issue any instructions and forms that are consistent with and necessary to implement subdivisions (e), (f), (h), and (i) of Section 14132.100, and Section (A), and Sections (D) through (L), at pages 6 through 6R, of Attachment 4.19-B to the California Medicaid State Plan in effect on January 1, 2003, relating to the reimbursement rate methodologies for federally qualified health center services and rural health clinic services. The adoption of these instructions and forms shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Actions pursuant to this subdivision must be taken within 30 days following the effective date of the act adding this section.

(d) This section shall remain in effect only until July 1, 2006, and as of that date is repealed, unless a later enacted statute, that is enacted before July 1, 2006, deletes or extends that date.

SEC. 21. Section 14132.107 is added to the Welfare and Institutions Code, to read:

14132.107. Claims for reimbursement under subdivision (e) of Section 14132.100 shall be finalized by the department within 150 days of receipt of the claims for reimbursement. These claims for reimbursement shall be paid within 30 days of being finalized by the department. However, the payment of those amounts that are disputed shall be subject to the requirements, timeframes, and procedures specified in Section 14171. Scope changes going forward shall be finalized within 90 days of receipt and paid within 30 days of being finalized by the department.

SEC. 22. Section 14132.108 is added to the Welfare and Institutions Code, to read:

14132.108. Notwithstanding any other provision of law, requests for rate adjustments for scope-of-service rate changes under paragraph (4) of subdivision (e) of Section 14132.100 for an FQHC's or RHC's fiscal year ending in 2004 shall be deemed to have been filed in a timely manner so long as it is filed within 90 days following the end of the 150-day timeframe applicable to scope-of-service changes occurring from January 1, 2001, to the end of an FQHC's or RHC's 2003 fiscal year, as specified in paragraph (6) of subdivision (e) of Section 14132.100.

SEC. 23. Section 14133.01 is added to the Welfare and Institutions Code, to read:

14133.01. (a) Notwithstanding any other provision of law, the director or his or her designee may apply prior authorization by designing a sampling methodology that will result in a generally acceptable audit standard for approval of a treatment authorization request (TAR), or a class of TARs. The director or his or her designee shall determine the applicable sampling methodology based upon health care industry standards and discussions with applicable Medi-Cal providers or their representatives. This sampling methodology shall be implemented by no later than July 1, 2005, and an outline of it shall be provided to the fiscal and policy committees of both houses of the Legislature. It is the intent of the Legislature for the department to review the sampling methodology on an ongoing basis and update it as applicable on a periodic basis in order to keep abreast of health care industry trends and the need to manage an efficient and effective Medi-Cal program.

(b) The department shall pursue additional means to improve and streamline the treatment authorization request process including, where applicable, those identified by independent analyses such as the July 2003 report by the California Healthcare Foundation entitled Medi-Cal Treatment Authorizations and Claims Processing: Improving Efficiency and Access to Care, and those identified by Medi-Cal providers. It is the Legislature's intent that any identified improvements be cost-beneficial to the state and to the Medi-Cal program as a whole.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific, this section by means of all-county letters, provider bulletins, or similar instructions. Thereafter, the department may adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 24. Section 14154.5 is added to the Welfare and Institutions Code, to read:

14154.5. (a) Each county shall work, on a routine basis, any error alert from the department's Medi-Cal Eligibility Data System (MEDS). Any alert that affects eligibility or the share of cost that is received by the 10th working day of the month shall be processed in time for the change to be effective the beginning of the following month. Any alert that affects eligibility or the share of cost that is received after the 10th working day of the month shall be processed in time for the change to be effective the beginning of the month after the following month. The department shall consult with the County Welfare Directors Association to define those alerts that affect eligibility or the share of cost.

(b) The county shall submit reconciliation files of its Medi-Cal eligible population to the department every three months, based upon a schedule determined by the department and in a format prescribed by the department, to identify any discrepancies between eligibility files in the county records and eligibility as reflected in MEDS. Counties shall be notified of any changes to the standard format for submitting reconciliation files sufficiently in advance to allow for budgeting, scheduling, development, testing, and implementation of any required change in county automated eligibility systems.

(c) For those records that are on the county's files, but not on MEDS, the county shall receive worker alerts from the department that identify these cases, and the county shall fix any data discrepancies. Any worker alert received by the 10th working day of the month shall be processed in time for the change to be effective the beginning of the following month. Any worker alert received after the 10th working day of the month shall be processed in time for the change to be effective the beginning of the month after the following month.

(d) In regard to any record that is on MEDS but not on the county's file, the county shall either correct the county record or MEDS, whichever is appropriate, within the same timeframes specified in subdivision (c).

(e) The department shall terminate a MEDS eligible record if the person is not eligible on the county's file when there has been no eligibility update on the MEDS record for six months.

(f) (1) If the department finds that a county is not performing all of the following activities, the county shall, within 60 days, submit a corrective action plan to the department for approval.

(A) Conducting reconciliations as required in subdivision (b).

(B) Processing 95 percent of worker alerts referred to in subdivisions (c) and (d), within the timeframes specified.

(C) Processing 90 percent of the error alerts referred to in subdivision (a) that affect eligibility or the share of cost, within the timeframes specified.

(2) The corrective action plan shall, at a minimum, include steps that the county shall take to improve its performance on the requirements with which the county is out of compliance. The plan shall establish interim benchmarks for improvement that shall be expected to be met by the county in order to avoid sanctions.

(g) If the county does not meet the interim benchmarks for improvement standards, the department may, in its sole discretion, reduce the allocation of funds to that county in the following year by 2 percent. Any funds so reduced may be restored by the department if, in the determination of the department, sufficient improvement has been made by the county in meeting the performance standards during the year for which the funds were reduced.

(h) The department, in consultation with the County Welfare Directors Association, shall investigate features that could be installed in MEDS to reduce the number of alerts and streamline the reconciliation process.

(i) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all county letters, provider bulletins, or similar instructions. Thereafter, the department may adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 25. Section 14170.11 is added to the Welfare and Institutions Code, to read:

14170.11. (a) No person or entity shall submit a claim to the department or its fiscal intermediaries for reimbursement under the Medi-Cal program for a nerve conduction test or for electromyography unless the person or entity's records contains a copy, for each person performing each test or electromyography, for which a claim is submitted, a certificate or diploma of satisfactory completion of a neurology or physical medicine and rehabilitation residency program accredited by the Accreditation Council of Graduate Medical Education (ACGME).

(b) The department may identify by publication, in provider bulletins or similar instructions, requirements that reimbursement from the Medi-Cal program shall only be made for the provision of certain procedures, tests, examinations, or other medical services provided by persons who possess a particular level of education, experience, and

training as evidenced by satisfactory completion of medical residency programs or board certification in a particular field and that those submitting claims shall maintain a copy of this certificate or diploma.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific, this section by means of all county letters, provider bulletins, or similar instructions. Thereafter, the department may adopt regulations in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 26. Section 14464.5 of the Welfare and Institutions Code is amended to read:

14464.5. (a) For purposes of this article, the following definitions apply:

(1) ''Capitation payment'' means the monthly amount paid by the state to a designated Medi-Cal managed care plan in exchange for contracted health care services procured by means of the Medi-Cal managed care contracts described in paragraph (3).

(2) ''Capitation rate'' means the per member per month rate used to calculate the capitation payments.

(3) ''Medi-Cal managed care plan'' means any Medi-Cal managed care plan contracting with the department to provide services to enrolled Medi-Cal beneficiaries pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.9 (commencing with Section 14088), Article 2.91 (commencing with Section 14089), and Section 14087.51 of Chapter 7, or pursuant to this chapter, and that is also an organization that meets the criteria in Section 1396b(w)(7)(A)(viii) of Title 42 of the United States Code.

(4) ''Total operating revenue'' means non-Medicare amounts received by a managed care plan for the coverage or providing of all health care services, including amounts received in exchange for health care procured by means of a Medi-Cal managed care contract as described in paragraph (3). Total operating revenue does not include amounts received by a managed care plan pursuant to a subcontract with a Medi-Cal managed care plan to provide health care services to Medi-Cal beneficiaries.

(b) The department shall impose, on an annual basis, a quality improvement fee no earlier than January 1, 2005. The quality improvement fee shall be paid to the state monthly and shall be 6 percent of each Medi-Cal managed care plan's total operating revenue. The quality improvement fee shall be subject to all of the following provisions:

(1) The quality improvement fee shall be paid monthly to the state and is due within 15 calendar days following the close of each month and shall be calculated on the prior month's total operating revenue as defined in paragraph (4) of subdivision (a).

(2) The quality improvement fee shall be deposited in the General Fund.

(3) If the Medi-Cal managed care plan does not timely pay the quality improvement fee, or any part thereof, the department may offset the amount of the fee that is unpaid against any amounts due from the state to the Medi-Cal managed care plan. Notwithstanding any such offset, the methodology for determining the fee as set forth in this subdivision shall be followed.

(4) The department shall make retrospective adjustments as necessary to the amounts calculated pursuant to this subdivision in order to assure that the Medi-Cal managed care plan's aggregate quality improvement fee for any particular state fiscal year does not exceed 6 percent of the total operating revenue for the Medi-Cal managed care plan for that year.

(5) If, on account of delay in the adoption of the annual Budget Act, or for any other reason, a Medi-Cal managed care plan is not paid by the department for a period in excess of 30 days, the payment date for the fee specified in paragraph (1) shall be extended until 45 days following the date that regular payments are resumed to the plans.

(6) On or before August 31 of each year, each Medi-Cal managed care plan subject to the quality improvement fee shall report to the department, in a prescribed form, the plan's total operating revenue as defined in paragraph (4) of subdivision (a) for the preceding state fiscal year.

(7) Any fee imposed pursuant to this section shall not be considered to be an administrative cost for purposes of Section 1378 of the Health and Safety Code, Section 14087.101, 14087.103, or 14087.105, or any regulation adopted pursuant to those sections.

(c) (1) The department shall implement this section in a manner that complies with federal requirements. If the department is unable to comply with the federal requirements for federal matching funds under this section, the quality improvement fee shall not be assessed or collected.

(2) The director may alter the methodology specified in this section for calculating the quality improvement fee to the extent necessary to meet the requirement of federal law or regulations.

(3) If, after implementation of this section, federal disapproval of the quality improvement fee program as described in this section occurs, any

fees paid by the plans to the department in any period for which such disapproval is effective shall be refunded to the plans.

(d) In addition to the Medi-Cal capitation rates that a Medi-Cal managed care plan would otherwise receive for providing services to Medi-cal beneficiaries, the capitation rates shall be increased in an amount determined by the department, subject to the following requirements:

(1) The additional Medi-Cal reimbursement provided by this section shall be distributed under a capitation payment methodology or on any other federally permissible basis.

(2) The additional Medi-Cal reimbursement provided by this section shall not supplant the payments otherwise due to any Medi-Cal managed care plan in the absence of such an additional reimbursement.

(3) Additional reimbursement provided by this section to any particular Medi-Cal managed care plan shall not cause the total reimbursement paid to that plan to exceed any applicable limit on payments as established pursuant to federal law and regulations.

(e) The director, or his or her designee, shall administer this section.

(f) The director may adopt regulations as are necessary to implement this section. These regulations shall be adopted as emergency regulations in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). For purposes of this section, the adoption of regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, and safety or general welfare. The regulations shall include, but not be limited to, any regulations necessary for either of the following purposes:

(1) The administration of this section, including the proper imposition and collection of the quality improvement fees.

(2) The development of any forms necessary to calculate, notify, collect, and distribute the quality improvement fees.

(g) As an alternative to subdivision (f), and notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement this section by means of a provider bulletin, contract amendment, policy letter, or other similar instructions, without taking regulatory action.

(h) To the extent permitted by federal law, any limitation on rates to the Medi-Cal managed care plan based on Medi-Cal fee-for-service costs shall be increased to include any capitation rate increase related to the quality improvement fee in subdivision (b).

(i) This section shall become inoperative on January 1, 2009, and, as of July 1, 2009, is repealed, unless a later enacted statute, that becomes

effective on or before July 1, 2009, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 26.1. Section 14552.5 is added to the Welfare and Institutions Code, to read:

14552.5. Pursuant to Section 14043.46, the department may implement a one-year moratorium on the certification and enrollment into the Medi-Cal program of new adult day health care centers.

SEC. 26.2. Section 14574 of the Welfare and Institutions Code is amended to read:

14574. (a) The director shall terminate the Medi-Cal certification of any adult day health care provider at any time if he or she finds the provider is not in compliance with standards prescribed by this chapter or Chapter 7 (commencing with Section 14000) or regulations adopted pursuant to these chapters. The director shall give reasonable notice of his or her intention to terminate the certification to the provider and participants in the center. The notice shall state the effective date of, and the reason for, the termination.

(b) The denial, suspension, or termination of certification shall be considered grounds for denial, suspension, or revocation of the license.

(c) The California Department of Aging and the department shall coordinate proceedings to deny an application for certification, to terminate or suspend certification, or to revoke or suspend licensure to the extent appropriate to ensure consistency and uniformity.

(d) The provider shall have the right to appeal the department's decision made pursuant to Section 14123.

(e) This section is not applicable to denials of initial certification made pursuant to a moratorium imposed in accordance with Section 14043.46 of the Welfare and Institutions Code.

SEC. 27. Section 16809 of the Welfare and Institutions Code, as amended by Section 75 of Chapter 230 of the Statutes of 2003, is amended to read:

16809. (a) (1) The board of supervisors of a county that contracted with the department pursuant to Section 16709 during the 1990–91 fiscal year and any county with a population under 300,000, as determined in accordance with the 1990 decennial census, by adopting a resolution to that effect, may elect to participate in the County Medical Services Program. The County Medical Services Program shall have responsibilities for specified health services to county residents certified eligible for those services by the county.

(2) If the County Medical Services Program Governing Board contracts with the department to administer the County Medical Services Program, that contract shall include, but need not be limited to, all of the following:

(A) Provisions for the payment to participating counties for making eligibility determinations based on the formula used by the County Medical Services Program for the 1993–94 fiscal year.

(B) Provisions for payment of expenses of the County Medical Services Program Governing Board.

(C) Provisions relating to the flow of funds from counties' vehicle license fees, sales taxes, and participation fees and the procedures to be followed if a county does not pay those funds to the program.

(D) Those provisions, as applicable, contained in the 1993–94 fiscal year contract with counties under the County Medical Services Program.

(3) The contract between the department and the County Medical Services Program Governing Board shall require that the County Medical Services Program Governing Board shall reimburse three million five hundred thousand dollars ($3,500,000) for the state costs of providing administrative support to the County Medical Services Program. The department may decline to implement decisions made by the governing board that would require a greater level of administrative support than that for the 1993–94 fiscal year. The department may implement decisions upon compensation by the governing board to cover that increased level of support.

(4) The contract between the department and the County Medical Services Program Governing Board may include provisions for the administration of a pharmacy benefit program and, pursuant to these provisions, the department may negotiate, on behalf of the County Medical Services Program, rebates from manufacturers that agree to participate. The governing board shall reimburse the department for staff costs associated with this paragraph.

(5) The department shall administer the County Medical Services Program pursuant to the provisions of the 1993–94 fiscal year contract with the counties and regulations relating to the administration of the program until the County Medical Services Program Governing Board executes a contract for the administration of the County Medical Services Program and adopts regulations for that purpose.

(6) The department shall not be liable for any costs related to decisions of the County Medical Services Program Governing Board that are in excess of those set forth in the contract between the department and the County Medical Services Program Governing Board.

(b) Each county intending to participate in the County Medical Services Program pursuant to this section shall submit to the Governing Board of the County Medical Services Program a notice of intent to contract adopted by the board of supervisors no later than April 1 of the fiscal year preceding the fiscal year in which the county will participate in the County Medical Services Program.

(c) A county participating in the County Medical Services Program pursuant to this section shall not be relieved of its indigent health care obligation under Section 17000.

(d) (1) The County Medical Services Program Account is established in the County Health Services Fund. The County Medical Services Program Account is continuously appropriated, notwithstanding Section 13340 of the Government Code, without regard to fiscal years. The following amounts may be deposited in the account:

(A) Any interest earned upon money deposited in the account.

(B) Moneys provided by participating counties or appropriated by the Legislature to the account.

(C) Moneys loaned pursuant to subdivision (q).

(2) The methods and procedures used to deposit funds into the account shall be consistent with the methods used by the program during the 1993–94 fiscal year.

(e) Moneys in the program account shall be used by the department, pursuant to its contract with the County Medical Services Program Governing Board, to pay for health care services provided to the persons meeting the eligibility criteria established pursuant to subdivision (j) and to pay for the expense of the governing board as set forth in the contract between the board and the department. In addition, moneys in this account may be used to reimburse the department for state costs pursuant to paragraph (3) of subdivision (a).

(f) (1) Moneys in this account shall be administered on an accrual basis and notwithstanding any other provision of law, except as provided in this section, shall not be transferred to any other fund or account in the State Treasury except for purposes of investment as provided in Article 4 (commencing with Section 16470) of Chapter 3 of Part 2 of Division 4 of Title 2 of the Government Code.

(2) (A) All interest or other increment resulting from the investment shall be deposited in the program account, at the end of the 1982–83 fiscal year and every six months thereafter, notwithstanding Section 16305.7 of the Government Code.

(B) All interest deposited pursuant to subparagraph (A) shall be available to reimburse program-covered services, County Medical Services Program Governing Board expenses, or for expenditures to augment the program's rates, benefits, or eligibility criteria pursuant to subdivision (j).

(g) A separate County Medical Services Program Reserve Account is established in the County Health Services Fund. Six months after the end of each fiscal year, any projected savings in the program account shall be transferred to the reserve account, with final settlement occurring no more than 12 months later. Moneys in this account shall be

utilized when expenditures for health services made pursuant to subdivision (j) for a fiscal year exceed the amount of funds available in the program account for that fiscal year. When funds in the reserve account are estimated to exceed 10 percent of the budget for health services for all counties electing to participate in the County Medical Services Program under this section for the fiscal year, the additional funds shall be available for expenditure to augment the rates, benefits, or eligibility criteria pursuant to subdivision (j) or for reducing the participation fees as determined by the County Medical Services Program Governing Board pursuant to subdivision (i). Nothing in this section shall preclude the CMSP Governing Board from establishing other reserves.

(h) Moneys in the program account and the reserve account, except for moneys provided by the state in excess of the amount required to fund the state risk specified in subdivision (j), and any funds loaned pursuant to subdivision (q) shall not be transferred to any other fund or account in the State Treasury except for purposes of investment as provided in Article 4 (commencing with Section 16470) of Chapter 3 of Part 2 of Division 4 of Title 2 of the Government Code. All interest or other increment resulting from investment shall be deposited in the program account, notwithstanding Section 16705.7 of the Government Code.

(i) (1) Counties shall pay participation fees as established by the County Medical Services Program Governing Board and their jurisdictional risk amount in a method that is consistent with that established in the 1993–94 fiscal year.

(2) A county may request, due to financial hardship, the payments under paragraph (1) be delayed. The request shall be subject to approval by the CMSP Governing Board.

(3) Payments made pursuant to this subdivision shall be deposited in the program account.

(4) Payments may be made as part of the deposits authorized by the county pursuant to Sections 17603.05 and 17604.05.

(j) (1) (A) For the 1991–92 fiscal year and all preceding fiscal years, the state shall be at risk for any costs in excess of the amounts deposited in the reserve fund.

(B) (i) Beginning in the 1992–93 fiscal year and for each fiscal year thereafter, counties and the state shall share the risk for cost increases of the County Medical Services Program not funded through other sources. The state shall be at risk for any cost that exceeds the cumulative annual growth in dedicated sales tax and vehicle license fee revenue, up to the amount of twenty million two hundred thirty-seven thousand four hundred sixty dollars ($20,237,460) per fiscal year, except for the 1999–2000, 2000–01, 2001–02, 2002–03, 2003–04, and 2004–05 fiscal

years. Counties shall be at risk up to the cumulative annual growth in the Local Revenue Fund created by Section 17600, according to the table specified in paragraph (2), to the County Medical Services Program, plus the additional cost increases in excess of twenty million two hundred thirty-seven thousand four hundred sixty dollars ($20,237,460) per fiscal year, except for the 1999–2000, 2000–01, 2001–02, 2002–03, 2003–04, and 2004–05 fiscal years. In the 1994–95 fiscal year, the amount of the state risk shall be twenty million two hundred thirty-seven thousand four hundred sixty dollars ($20,237,460) per fiscal year, in addition to the cost of administrative support pursuant to paragraph (3) of subdivision (a).

(ii) For the 1999–2000, 2000–01, 2001–02, 2002–03, 2003–04, and 2004–05 fiscal years, the state shall not be at risk for any cost that exceeds the cumulative annual growth in dedicated sales tax and vehicle license fee revenue. Counties shall be at risk up to the cumulative annual growth in the Local Revenue Fund created by Section 17600, according to the table specified in paragraph (2), to the County Medical Services Program, plus any additional cost increases for the 1999–2000, 2000–01, 2001–02, 2002–03, 2003–04, and 2004–05 fiscal years.

(C) The CMSP Governing Board, after consultation with the department, shall establish uniform eligibility criteria and benefits for the County Medical Services Program.

(2) For the 1991–92 fiscal year, jurisdictional risk limitations shall be as follows:

Jurisdiction	Amount
Alpine	$ 13,150
Amador	620,264
Butte	5,950,593
Calaveras	913,959
Colusa	799,988
Del Norte	781,358
El Dorado	3,535,288
Glenn	787,933
Humboldt	6,883,182
Imperial	6,394,422
Inyo	1,100,257
Kings	2,832,833
Lassen	687,113
Madera	2,882,147
Marin	7,725,909
Mariposa	435,062

Modoc	469,034
Mono	369,309
Napa	3,062,967
Nevada	1,860,793
Plumas	905,192
San Benito	1,086,011
Shasta	5,361,013
Sierra	135,888
Siskiyou	1,372,034
Solano	6,871,127
Sonoma	13,183,359
Sutter	2,996,118
Tehama	1,912,299
Trinity	611,497
Tuolumne	1,455,320
Yuba	2,395,580

(3) Beginning in the 1991–92 fiscal year and in subsequent fiscal years, the jurisdictional risk limitation for the counties that did not contract with the department pursuant to Section 16709 during the 1990–91 fiscal year shall be the amount specified in paragraph (A) plus the amount determined pursuant to paragraph (B), minus the amount specified by the County Medical Services Program Governing Board as participation fees.

(A)

Jurisdiction	Amount
Lake	$1,022,963
Mendocino	1,654,999
Merced	2,033,729
Placer	1,338,330
San Luis Obispo	2,000,491
Santa Cruz	3,037,783
Yolo	1,475,620

(B) The amount of funds necessary to fully fund the anticipated costs for the county shall be determined by the CMSP Governing Board before a county is permitted to participate in the County Medical Services Program.

(4) For the 1994–95 and 1995–96 fiscal years, the specific amounts and method of apportioning risk to each participating county may be adjusted by the CMSP Governing Board.

(k) The Legislature hereby determines that an expedited contract process for contracts under this section is necessary. Contracts under this section shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code. Contracts of the department pursuant to this section shall have no force or effect unless they are approved by the Department of Finance.

(*l*) The state shall not incur any liability except as specified in this section.

(m) Third-party recoveries for services provided under this section pursuant to Article 3.5 (commencing with Section 14124.70) of Chapter 7 of Part 3 may be pursued.

(n) Under the program provided for in this section, the department may reimburse hospitals for inpatient services at the rates negotiated for the Medi-Cal program by the California Medical Assistance Commission, pursuant to Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 3, if the California Medical Assistance Commission determines that reimbursement to the hospital at the contracted rate will not have a detrimental fiscal impact on either the Medi-Cal program or the program provided for in this section. In negotiating and renegotiating contracts with hospitals, the commission may seek terms which allow reimbursement for patients receiving services under this section at contracted Medi-Cal rates.

(o) Any hospital which has a contract with the state for inpatient services under the Medi-Cal program and which has been approved by the commission to be reimbursed for patients receiving services under this section shall not deny services to these patients.

(p) Participating counties may conduct an independent program review to identify ways through which program savings may be generated. The counties and the department may collectively pursue identified options for the realization of program savings.

(q) The Department of Finance may authorize a loan of up to thirty million dollars ($30,000,000) for deposit into the program account to ensure that there are sufficient funds available to reimburse providers and counties pursuant to this section.

(r) Regulations adopted by the department pursuant to this section shall remain operative and shall be used to operate the County Medical Services Program until a contract with the County Medical Services Program Governing Board is executed and regulations, as appropriate, are adopted by the County Medical Services Program Governing Board. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part

1 of Division 3 of Title 2 of the Government Code, those regulations adopted under the County Medical Services Program shall become inoperative until January 1, 1998, except those regulations that the department, in consultation with the County Medical Services Program Governing Board, determines are needed to continue to administer the County Medical Services Program. The department shall notify the Office of Administrative Law as to those regulations the department will continue to use in the implementation of the County Medical Services Program.

(s) Moneys appropriated from the General Fund to meet the state risk as set forth in subparagraph (B) of paragraph (1) of subdivision (j) shall not be available for those counties electing to disenroll from the County Medical Services Program.

(t) This section shall remain in effect only until January 1, 2008, and as of that date is repealed, unless a later enacted statute, that is enacted on or before January 1, 2008, deletes or extends that date.

SEC. 28. Section 16809 of the Welfare and Institutions Code, as amended by Section 91 of Chapter 1161 of the Statutes of 2002, is amended to read:

16809. (a) The board of supervisors of a county that contracted with the department pursuant to Section 16709 during the 1990–91 fiscal year and any county with a population under 300,000, as determined in accordance with the 1990 decennial census, may enter into a contract with the department and the department may enter into a contract with that county under which the department agrees to administer the program responsibilities for specified health services to county residents certified eligible for those services by the county.

(b) Each county intending to contract with the department pursuant to this section shall submit to the department a notice of intent to contract adopted by the board of supervisors no later than April 1 of the fiscal year preceding the fiscal year for which the agreement will be in effect in accordance with procedures established by the department.

(c) A county contracting with the department pursuant to this section shall not be relieved of its indigent health care obligation under Section 17000.

(d) The department shall establish the County Medical Services Program Account in the County Health Services Fund. The County Medical Services Program Account is continuously appropriated, notwithstanding Section 13340 of the Government Code, without regard to fiscal years. The following amounts may be deposited in the account:

(1) Any interest earned upon money deposited in the account.

(2) Moneys provided by participating counties or appropriated by the Legislature to the account.

(3) Moneys loaned pursuant to subdivision (q).

(e) Moneys in the program account shall be used by the department to pay for health care services provided to the persons meeting the eligibility criteria established pursuant to subdivision (j).

(f) (1) Moneys in this account shall be administered on an accrual basis and notwithstanding any other provision of law, except as provided in this section, shall not be transferred to any other fund or account in the State Treasury except for purposes of investment as provided in Article 4 (commencing with Section 16470) of Chapter 3 of Part 2 of Division 4 of Title 2 of the Government Code.

(2) (A) All interest or other increment resulting from the investment shall be deposited in the program account, at the end of the 1982–83 fiscal year and every six months thereafter, notwithstanding Section 16305.7 of the Government Code.

(B) All interest deposited pursuant to subparagraph (A) shall be available to reimburse program-covered services, or for expenditures to augment the program's rates, benefits, or eligibility criteria pursuant to subdivision (j).

(g) The department shall establish a separate County Medical Services Program Reserve Account in the County Health Services Fund. Six months after the end of each fiscal year, any projected savings in the program account shall be transferred to the reserve account, with final settlement occurring no more than 12 months later. Moneys in this account shall be utilized when expenditures for health services made pursuant to subdivision (j) for a fiscal year exceed the amount of funds available in the program account for that fiscal year. When funds in the reserve account are estimated to exceed 10 percent of the budget for health services for all counties electing to contract with the department under this section for the fiscal year, the additional funds shall be available for expenditure to augment the rates, benefits, or eligibility criteria pursuant to subdivision (j) or for reducing the participation fees required by Section 16809.3.

(h) Moneys in the program account and the reserve account, except for moneys provided by the state in excess of the amount required to fund the state risk specified in subdivision (j), and any funds loaned pursuant to subdivision (q), shall not be transferred to any other fund or account in the State Treasury except for purposes of investment as provided in Article 4 (commencing with Section 16470) of Chapter 3 of Part 2 of Division 4 of Title 2 of the Government Code. All interest or other increment resulting from investment shall be deposited in the program account, notwithstanding Section 16705.7 of the Government Code.

(i) (1) Counties shall pay by the 15th of each month the agreed-upon contract amount. In the event a county does not make the agreed-upon

monthly payment, the department may terminate the county's participation in the program.

(2) A county may request, due to financial hardship, the payments under paragraph (1) be delayed. The request shall be subject to approval by the Small County Advisory Committee.

(3) Payments made pursuant to this subdivision shall be deposited in the program account.

(4) Payments may be made as part of the deposits authorized by the county pursuant to Sections 17603.05 and 17604.05.

(j) (1) (A) For the 1991–92 fiscal year and all preceding fiscal years, the state shall be at risk for any costs in excess of the amounts deposited in the reserve fund.

(B) Beginning in the 1992–93 fiscal year and for each fiscal year thereafter, counties and the state shall share the risk for cost increases of the County Medical Services Program not funded through other sources. The state shall be at risk for any cost that exceeds the cumulative annual growth in dedicated sales tax and vehicle license fee revenue, up to the amount of twenty million two hundred thirty-seven thousand four hundred sixty dollars ($20,237,460) per fiscal year, except for the 1999–2000, 2000–01, 2001–02, 2002–03, 2003–04, and 2004–05 fiscal years. Counties shall be at risk up to the cumulative annual growth in the Local Revenue Fund created by Section 17600 according to the table specified in paragraph (2) to the County Medical Services Program, plus additional cost increases in excess of twenty million two hundred thirty-seven thousand four hundred sixty dollars ($20,237,460) per fiscal year.

(C) As a condition of the state assuming this risk, the department may require uniform eligibility criteria and benefits to be provided which shall be mutually established by participating counties in conjunction with the department. The County Medical Services Program Governing Board may revise these eligibility criteria and benefits or alter rates of payment in order to assure that expenditures do not exceed the funds available in the program account.

(2) For the 1991–92 fiscal year, jurisdictional risk limitations shall be as follows:

Jurisdiction	Amount
Alpine	$ 13,150
Amador	620,264
Butte	5,950,593
Calaveras	913,959
Colusa	799,988

Del Norte	781,358
El Dorado	3,535,288
Glenn	787,933
Humboldt	6,883,182
Imperial	6,394,422
Inyo	1,100,257
Kings	2,832,833
Lassen	687,113
Madera	2,882,147
Marin	7,725,909
Mariposa	435,062
Modoc	469,034
Mono	369,309
Napa	3,062,967
Nevada	1,860,793
Plumas	905,192
San Benito	1,086,011
Shasta	5,361,013
Sierra	135,888
Siskiyou	1,372,034
Solano	6,871,127
Sonoma	13,183,359
Sutter	2,996,118
Tehama	1,912,299
Trinity	611,497
Tuolumne	1,455,320
Yuba	2,395,580

(3) Beginning in the 1991–92 fiscal year and in subsequent fiscal years, the jurisdictional risk limitation for the counties that did not contract with the department pursuant to Section 16709 during the 1990–91 fiscal year shall be the amount specified in paragraph (A) plus the amount determined pursuant to paragraph (B), minus the amount specified in Section 16809.3.

(A)

Jurisdiction	Amount
Lake	1,022,963
Mendocino	1,654,999
Merced	2,033,729

Placer	1,338,330
San Luis Obispo	2,000,491
Santa Cruz	3,037,783
Yolo	1,475,620

(B) The amount of funds necessary to fully fund the anticipated costs for the county shall be determined by the department. This amount shall be subject to the approval of both the Department of Finance and the Small County Advisory Committee before a county is permitted to contract back with the department.

(4) For the 1992–93 fiscal year and fiscal years thereafter, the amounts of the jurisdictional risk limitations shall be adjusted according to the provisions of paragraph (2).

(k) The Legislature hereby determines that an expedited contract process for contracts under this section is necessary. Contracts under this section shall be exempt from the provisions of Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code. Contracts shall have no force and effect unless approved by the Department of Finance.

(*l*) The state shall not incur any liability except as specified in this section.

(m) The department may pursue third-party recoveries for services provided under this section pursuant to Article 3.5 (commencing with Section 14124.70) of Chapter 7 of Part 3.

(n) Under the program provided for in this section, the department shall reimburse hospitals for inpatient services at the rates negotiated for the Medi-Cal program by the California Medical Assistance Commission, pursuant to Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 3, if the California Medical Assistance Commission determines that reimbursement to the hospital at the contracted rate will not have a detrimental fiscal impact on either the Medi-Cal program or the program provided for in this section. In negotiating and renegotiating contracts with hospitals, the commission may seek terms which allow reimbursement for patients receiving services under this section at contracted Medi-Cal rates.

(o) Any hospital which has a contract with the state for inpatient services under the Medi-Cal program and which has been approved by the commission to be reimbursed for patients receiving services under this section shall not deny services to these patients.

(p) Participating counties may conduct an independent program review to identify ways through which program savings may be generated. The counties and the department shall collectively pursue identified options for the realization of program savings.

(q) The Department of Finance may authorize a loan of up to thirty million dollars ($30,000,000) for deposit into the program account to ensure that there are sufficient funds available to reimburse providers and counties pursuant to this section.

(r) This section shall become operative January 1, 2008.

SEC. 29. Section 22003 of the Welfare and Institutions Code is amended to read:

22003. (a) Individuals who participate in the program and have resources above the eligibility levels for receipt of medical assistance under Title XIX of the Social Security Act (Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code) shall be eligible to receive those in-home supportive services benefits specified by the State Department of Social Services, and those Medi-Cal benefits specified by the State Department of Health Services, for which they would otherwise be eligible, if, prior to becoming eligible for benefits, they have purchased a long-term care insurance policy or a health care service plan contract covering long-term care that has been certified by the State Department of Health Services pursuant to this division.

(b) Individuals may purchase approved and certified long-term care insurance policies or health care service plan contracts which cover long-term care services in amounts equal to the resources they wish to protect, so long as the amount of insurance purchased exceeds the minimum level set by the State Department of Health Services pursuant to Section 22009.

(c) The resource protection provided by this division shall be effective only for long-term care policies, and health care service plan contracts that cover long-term care services, when the policy or contract is delivered, issued for delivery, or renewed on July 1, 1993 and thereafter.

SEC. 30. Section 22005.2 is added to the Welfare and Institutions Code, to read:

22005.2. Each organization issuing policies certified by the State Department of Health Services under this division shall each year contribute to a fund to be used for common educational and marketing expenses for reaching the target population designated by the California Partnership for Long-Term Care. The amount of each participating issuer’s required annual contribution shall be determined by the department and shall not be less than twenty thousand dollars ($20,000).

SEC. 31. Section 22009 of the Welfare and Institutions Code is amended to read:

22009. (a) The State Department of Health Services shall adopt regulations to implement this division, including, but not limited to, regulations which establish:

(1) The population and age groups that are eligible to participate in the program.

(2) The minimum level of long-term care insurance or long-term care coverage included in health care service plan contracts that must be purchased to meet the requirement of subdivision (b) of Section 22003.

(3) The amount and types of services that a long-term care insurance policy or health care service plan contract which includes long-term care services must cover to meet the requirements of this division.

(4) Which coordinating entities are designated and approved to deliver individual assessment and case management services to individuals in a community setting, as required by subdivision (b) of Section 22006.

(5) The disability criteria for eligibility for long-term care benefits as required by subdivision (c) of Section 22006.

(6) The specific eligibility requirements for receipt of the Medi-Cal benefits provided for by the program, and those Medi-Cal benefits for which participants in the program shall be eligible.

(b) The State Department of Social Services shall also adopt regulations to implement this division, including, but not limited to, regulations that establish:

(1) The specific eligibility requirements for in-home supportive services benefits.

(2) Those in-home supportive services benefits for which participants in the program shall be eligible.

(c) The State Department of Health Services and the State Department of Social Services shall also jointly adopt regulations that provide for the following:

(1) Continuation of benefits pursuant to Section 22008.5.

(2) The protection of a participant's resources pursuant to Section 22004, and the ratio of resources to long-term care benefit payments as described in subdivision (c) of Section 22004.

(d) The departments shall adopt emergency regulations pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code to implement this division. The adoption of regulations pursuant to this section in order to implement this division shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, or safety.

Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, emergency regulations adopted pursuant to this section shall not be subject to the

review and approval of the Office of Administrative Law. The regulations shall become effective immediately upon filing with the Secretary of State. The regulations shall not remain in effect more than 120 days unless the adopting agency complies with all of the provisions of Chapter 3.5 (commencing with Section 11340) as required by subdivision (c) of Section 11346.1 of the Government Code.

SEC. 31.5. Section 80.5 of Chapter 230 of the Statutes of 2003 is repealed.

SEC. 32. (a) The Legislature finds and declares that the state faces a fiscal crisis that requires unprecedented measures to be taken to reduce General Fund expenditures.

(b) (1) Notwithstanding any other provision of law, for acute care hospitals not under contract with the State Department of Health Services, the amount for inpatient services provided to Medi-Cal recipients during the 2004–05 fiscal year shall not exceed the amount determined pursuant to paragraph (3).

(2) For purposes of this subdivision, the reimbursement for inpatient services includes the amounts paid for all categories of inpatient services allowable by Medi-Cal. The reimbursement includes the amounts paid for routine services, together with all related ancillary services.

(3) (A) The maximum payment for services provided during the 2004–05 fiscal year shall be calculated using the ''as audited'' cost per day, including ancillary costs, for the hospital's fiscal period ending in the 2003 calendar year.

(B) When calculating a hospital's cost report settlement for a hospital's fiscal period ending in the 2004–05 fiscal year that is subject to paragraph (1), the settlement shall be limited to the lower of either the hospital's cost per day for inpatient services provided during the 2004–05 fiscal year or the ''as audited'' cost per day for the hospital's fiscal period ending in the 2003 calendar year multiplied by the number of inpatient days rendered during the 2004–05 fiscal year.

(c) Notwithstanding any other provision of law, for acute care hospitals not under contract with the State Department of Health Services pursuant to Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code, the amounts paid for inpatient hospital services provided during the 2004–05 fiscal year as interim payments shall be reduced by 10 percent with respect to the interim rate on file and in effect on January 1, 2004, as established pursuant to Section 51536 of Title 22 of the California Code of Regulations. The room rates on file for purposes of Section 51536 of Title 22 of the California Code of Regulations on January 1, 2004, shall be used for the period of July 1, 2004, through June 30, 2005, and requests for room rate increases shall not be processed. This section

shall not affect the final settlement process or amounts as determined pursuant to subdivision (b) or Section 51536 of Title 22 of the California Code of Regulations.

(d) It is the intent of the Legislature that the California Medical Assistance Commission freeze all Medi-Cal reimbursement rates paid to hospitals for inpatient services at their 2003–04 contract rate, or at a lower level, whichever is applicable based on contract negotiations.

(e) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the Director of Health Services may implement subdivision (b) by means of a provider bulletin, or similar instruction, without taking regulatory action.

(f) The Director of Health Services shall promptly seek all necessary federal approvals in order to implement this section, including necessary amendments to the state plan.

(g) Implementation of Section 14105.18 of the Welfare and Institutions Code shall be based on the rates of payment pursuant to the Medi-Cal program excluding the reduction in interim payments required by subdivision (c).

SEC. 33. In response to a report of the United States Department of Justice, Civil Rights Division, pursuant to the Civil Rights of Institutionalized Persons Act (42 U.S.C. Sec. 1997 and following), regarding the operation of the Metropolitan State Hospital, the State Department of Mental Health shall do all of the following with respect to the Metropolitan State Hospital:

(a) Commencing July 15, 2004, report to the appropriate fiscal and policy committees of the Legislature on a quarterly basis regarding key measures that pertain to patient care and the operation of the Metropolitan State Hospital. These key measures shall, at a minimum, include all of the following:

(1) Rate of readmission to an inpatient facility that occurs within 30 days of a previous discharge from the Metropolitan State Hospital.

(2) Number of patient injury events per patient day.

(3) Number of elopements per inpatient day.

(4) Ratio of the number of medication errors reported to the duplicated count of clients served during the reporting period.

(5) Proportion of patients receiving scheduled antipsychotic medications that receive new generation agents.

(6) Data regarding seclusion and restraint use, including hours of restraint as a percent of inpatient hours, percent of clients restrained at least once during the reporting period, hours of seclusion as a percent of inpatient hours, and percent of patients secluded at least once during the reporting period.

(b) Commencing July 15, 2004, provide to the appropriate fiscal and policy committees of the Legislature all of the following:

(1) All future correspondence between the United States Department of Justice and the State Department of Mental Health regarding Metropolitan State Hospital.

(2) Quarterly updates of the Metropolitan State Hospital ''Summary Grid'' for compliance.

(c) Convene at least two community forums within the 2004–05 fiscal year at the Metropolitan State Hospital to provide a discussion opportunity with individuals regarding the work in progress for meeting the requirements of the United States Department of Justice. These forums shall provide the opportunity to tour programs at the facility as appropriate on those days the forums are convened, or at other times as arranged by the facility within a timely manner.

SEC. 34. The State Department of Mental Health, in collaboration with the Department of Managed Health Care, the Department of Insurance, and applicable representatives from the California public and private mental health systems, shall identify the core reasons that mental health parity in California is not being achieved, the barriers to achieving that parity, and what approaches over the short-term and long-term can be done to effectuate a more comprehensive mental health system in California, both public and private. The State Department of Mental Health shall submit a report of this information to the appropriate policy committees of the Legislature on or before March 1, 2005.

SEC. 35. It is the intent of the Legislature that retroactive payments owed to Federally Qualified Health Centers and Rural Health Centers for the period that began January 1, 2001, and proceeds through June 30, 2004, shall be made in the 2004–05 fiscal year.

SEC. 36. The State Department of Health Services, in collaboration with the County Welfare Directors Association, shall develop options and recommendations for modifying the budgeting and allocation methodologies for county Medi-Cal administration. The recommendations shall, at a minimum, consider the number of eligible cases, the complexity of cases, the way in which caseload growth funds are allocated, and the workload associated with denied applications. The department shall consider options for the establishment of productivity features that result in efficient and effective administration of the Medi-Cal program, including accurate and timely determinations of eligibility and redeterminations and reasonable access to eligibility services for potential eligibles. The department shall report the options and recommendations developed pursuant to this section to all fiscal committees of both houses of the Legislature on or before January 10, 2005.

SEC. 36.5. The State Department of Developmental Services shall develop a methodology for apportioning the 2004-05 unallocated reduction from the General Fund of seven million dollars ($7,000,000) to the regional center purchase-of-service budget and shall provide this information to the fiscal and applicable policy committees of both houses of the Legislature on or before December 1, 2004. The department shall also provide a summary of the approved components of the regional center plans to meet the unallocated amount as required in Section 4631.5 of the Welfare and Institutions Code.

SEC. 37. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because in that regard this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

However, notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed one million dollars ($1,000,000), reimbursement shall be made from the State Mandates Claims Fund. amount as required in Section 4631.5 of the Welfare and Institutions Code.

SEC. 38. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make the necessary statutory changes to implement the Budget Act of 2004 at the earliest possible time, it is necessary that this act take effect immediately.

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